A meeting of the **Forth Valley NHS Board** will be held on **Tuesday 24 February 2026** at **9.30am** in the **Boardroom, Carseview House, Castle Business Park, Stirling FK9 4SW**.

Neena Mahal
Chair

AGENDA

1.	**Welcome, Apologies and Confirmation of Quorum**		**09.30**
2.	**Declaration(s) of Interest(s)**		
3.	**Minute of Forth Valley NHS Board meeting held on 27 January 2026**	For Ratification **Pages 5 to 19**	
4.	**Matters Arising from the Minute / Action Log**	For Approval **Pages 20 to 22**	
5.	**Chair's Report** (a) Verbal Update by Ms Neena Mahal, Board Chair (b) Board Seminar Update	For Assurance **Page 23**	**9.40**
6.	**Board Executive Team Report** (Paper presented by Professor Ross McGuffie, Chief Executive)	For Discussion **Pages 24 to 28**	**9.50**
	7. COMMITTEE MINUTES AND AN OPPORTUNITY FOR COMMITTEE CHAIRS TO HIGHLIGHT MATERIAL ISSUES TO THE BOARD		**10.00**
	Governance Committee Minutes		
7.1	**Audit & Risk Committee – Minute of Meeting of 23 January 2026** (Presented by Cllr Fiona Collie, Committee Chair)	For Assurance **Pages 29 to 38**	
7.2	**Clinical Governance Committee – Minute of Meeting of 13 January 2026** (Presented by Mr John Stuart, Committee Chair)	For Assurance **Pages 39 to 51**	
	Advisory Committee Minutes		
7.3	**Area Partnership Forum – Minute of Meeting of 16 December 2025** (Presented by Mr Robert Clark, APF Co-Chair)	For Noting **Pages 52 to 55**	
	INTEGRATION JOINT BOARDS		
7.4	**Minute of Clackmannanshire & Stirling Integration Joint Board – 26 November 2025**	For Assurance **Pages 56 to 67**	
7.5	**Minute of Falkirk Integration Joint Board – 5 December 2025**	For Assurance **Pages 68 to 78**	

FOR APPROVAL			
8.	**Anti-Racism Plan and Communications Plan** (Paper presented by Ms Linda McGovern, Deputy Director of Workforce)	For Decision **Pages 79 to 245**	**10.30**
9.	**Robotic Assisted Surgery in NHS Forth Valley** (Paper presented by Mr Andrew Murray, Medical Director)	For Decision **Pages 246 to 317**	**10.55**
	FOR DISCUSSION & ASSURANCE		
10.	**Corporate Objectives 2025/26 Progress Update** (Paper presented by Professor Ross McGuffie, Chief Executive)	For Assurance **Pages 318 to 324**	**11.10**
	BREAK 11.35 to 11.50		
	Quality & Safety		
11.	**HIS Unannounced Mental Health Services Safe Delivery of Care Inspection - NHS Forth Valley** (Paper presented by Professor Karen Goudie, Executive Nursing Director)	For Assurance **Pages 325 to 398**	**11.50**
12.	**Spotlight on Services – Ward Product Management, Forth Valley Royal Hospital** (Paper presented by Mr Scott Urquhart, Director of Finance)	For Assurance **Pages 399 to 402**	**12.25**
	Finance & Performance		
13.	**Finance Report** (Paper presented by Mr Scott Urquhart, Director of Finance)	For Assurance **Pages 403 to 414**	**12.45**
14.	**Performance Report** (Paper presented by Ms Kerry Mackenzie, Acting Director of Strategic Planning & Performance)	For Assurance **Pages 415 to 472**	**1.00**
15.	**Schedule of Business**	For Information **Pages 473 to 474**	
16. ANY OTHER COMPETENT BUSINESS			
17. RISKS AND REFLECTIONS			
18.	**Date and Time of Next Meeting** Tuesday 28 April, 9.30am	For Noting	

Forth Valley NHS Board
Record of Attendance: 1 April 2025 to 31 March 2026

MEMBERS	29 April (special)	27 May	17 June (private)	29 July	30 Sept	25 November	27 January	24 February
Neena Mahal (Chair)	✓	✓	✓	✓	✓	✓	✓	
Kirstin Cassells	✓	✓	✓	✓	✓	✓	✓	
Jennifer Champion (from 10.09.25)					✓	✓	✓	
Robert Clark	✓	✓	✓	✓	✓	✓	✓	
Fiona Collie	✓	X	✓	✓	✓	✓	X	
Frances Dodd (demitted office 15 July 2025)	✓	✓	X					
Martin Fairbairn	✓	✓	✓	✓	✓	✓	✓	
Karen Goudie (from 16 July 2025)				✓	X	✓	✓	
Alison Jaap				✓	✓	✓	X	
Gordon Johnston	✓	✓	✓	✓	✓	✓	✓	
Fiona Law	✓	✓	✓	✓	✓	✓	✓	
Stephen McAllister	✓	✓	✓	✓	✓	✓	✓	
Ross McGuffie	✓	✓	✓	✓	✓	✓	✓	
Clare McKenzie				✓	✓	✓	✓	
Andrew Murray	✓	✓	✓	✓	✓	✓	✓	

Allan Rennie	✓	✓	X	✓	✓	✓	✓	
Finlay Scott				X	✓	✓	✓	
John Stuart	✓	✓	✓	✓	✓	✓	✓	
Scott Urquhart	✓	✓	✓	✓	✓	✓	✓	
David Wilson (until 30 November)	✓	✓	X	✓	✓	X		

Key:

✓ In attendance

X Apologies

O Non-attendance

FORTH VALLEY NHS BOARD

3. Minute of the Forth Valley NHS Board Meeting held on Tuesday 27 January 2026
For: Ratification

Minute of the Forth Valley NHS Board Meeting held on Tuesday 27 January 2026 at 9.30am in the Boardroom, Carseview House.

Present:
Ms Neena Mahal (Board Chair)
Ms Kirstin Cassells (Non-Executive Director)
Dr Jennifer Champion (Director of Public Health)
Mr Robert Clark (Non-Executive Director)
Mr Martin Fairbairn (Non-Executive Director)
Cllr Scott Farmer (Non-Executive Director)
Professor Karen Goudie (Executive Nurse Director)
Mr Gordon Johnston (Non-Executive Director)
Cllr Fiona Law (Non-Executive Director)
Mr Stephen McAllister (Non-Executive Director)
Professor Ross McGuffie (Chief Executive)
Professor Clare McKenzie (Non-Executive Director)
Mr Andrew Murray (Medical Director)
Mr Allan Rennie (Vice Chair)
Mr Finlay Scott (Non-Executive Director)
Mr John Stuart (Non-Executive Director)
Mr Scott Urquhart (Director of Finance)

In Attendance:
Dr Karen Adamson (Deputy Medical Director)
Dr Jennifer Borthwick (Interim Chief Officer, Clackmannanshire & Stirling IJB) (from item 12)
Ms Elsbeth Campbell (Head of Communications)
Mrs Morag Farquhar (Director of Facilities)
Mr Craig Finlayson (Senior Charge Nurse) Item 11
Mr Garry Fraser (Director of Acute Services)
Mr Jack Frawley (Board Secretary)
Mr Jonathan Horwood (Infection Control Manager & Clinical Lead) Item 9b
Kerry Mackenzie (Acting Director of Strategic Planning, Performance & Resources)
Ms Jackie McEwan (Corporate Business Manager)
Mr Kevin Reith (Director of People)
Ms Linda Stevenson (AHP Team Lead) Item 11
Miss Vicky Webb (Head of Risk Management)
Ms Gail Woodcock (Chief Officer, Falkirk IJB)

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1. Welcome, Apologies for Absence and Confirmation of Quorum

The Chair welcomed all present to the meeting and led the Board in welcoming Cllr Scott Farmer to his first Board meeting as a Non-Executive Director and Stirling Council nominee to the Board.

There were apologies from Cllr Fiona Collie and Alison Jaap. The Board meeting was quorate.

Laura Byrne and Scott Jaffray were not in attendance.

2. Declarations of Interest

There were no declarations of interest.

3. Minute of Meeting

The minute of the meeting held on 25 November 2025, subject to previous electronic circulation and Board member approval, was **confirmed** as a correct record.

4. Matters Arising from the Minute / Action Log

The Action Log was **reviewed** by the Board Chair and consideration was given to the actions still in progress.

Board members noted that actions 107, 108, 109, 110, 111, 112, 113 and 115 were marked as complete and would be removed from the Action Log.

A question was raised on the approach to incorporation of national EQIAs in local reporting. There would be further consideration of how to capture this in the Board report template to reflect that the national position had been considered in preparation of items.

The Forth Valley NHS Board approved the Action Log.

5. Chair's Report - Verbal Update by Ms Neena Mahal

The Board Chair highlighted the following:

(a) The Chair had undertaken a number of visits with the Chief Executive. There had been good Board member representation at the recent Value Based Health & Care (VBHC) Collaborative launch event. The event had been a great success with the messaging landing well with staff. Details of future Learning Sessions had been shared with Board members.

(b) Caroline Lamb, Director General Health & Social Care had visited the Frailty Unit on Friday 23 January and had been impressed with the service offered which was slightly different to that offered in other areas.

(c) There had been an MP/MSP briefing session in early December.

(d) The Short Life Working Group on Governance had been developing a Board & Committee Effectiveness Survey which would be circulated in coming weeks. The responses to the surveys would be used to inform the Board Seminar on governance in April.

(e) Board Members had been sent details of upcoming Sim Safety Club sessions to which they were invited.

The following points were made in discussion:

(i) Members echoed the view that the VBHC Collaborative launch had been an excellent event. Feedback from event organisers included that the Board support was evident and welcome.

(ii) The podcasts which were available as part of the Culture Change and Collaborative Leadership programme were highlighted as being an excellent resource featuring candid and positive discussions.

The Forth Valley NHS Board noted the update from the Board Chair.

6. Chief Executive Update

(a) Board Executive Team Report

The Forth Valley NHS Board considered the Board Executive Team report, presented by Professor McGuffie, which provided an update on service areas celebrating success, key areas of activity by the Senior Leadership Team, and upcoming issues.

Key messages in the report included:

(i) Burnbrae Care Home in Falkirk had been awarded grades of six and five, which is one of the most impressive inspection reports within the area. The collaboration across the system was well recognised within the report.

(ii) A new Workforce Wellbeing Framework (2025 – 2029) was launched at the beginning of January 2026 to help improve staff health and wellbeing.

(iii) The Person-Centred Care Team coordinated the purchase, wrapping and donation of 620 gifts for patients in Forth Valley Royal Hospital on Christmas Day. On Christmas morning, each patient received a hand-drawn card alongside their gift.

(iv) Freedom of Information request compliance required to be at 90% by December, with performance being at 93%, continuing the month-on-month performance above target. The backlog of enquiries had reduced from a high of over 200 cases to 0.

(v) The Value Based Health and Care Collaborative launched at an event held in Forth Valley Royal Hospital on Thursday 22nd January.

(vi) The Board received the Healthcare Improvement Scotland Unannounced Maternity Inspection Report on 27th November. The report recognised the compassionate and responsive care provided, strong multidisciplinary teamwork, visible senior leadership and staff health and wellbeing, whilst noting a number of improvements required including, delays in induction of labour, governance of adverse events and the need for better oversight of real-time staffing risks.

(vii) The inspection report around Mental Health Services was expected to be published on 28 January.

(viii) The Chief Executive was leading work nationally around Diagnostics, with a Strategic Needs Assessment underway that was focusing on imaging, clinical physiology, labs and endoscopy.

(ix) The Chief Executive and Falkirk Chief Officer were leading work around the Prisoner Healthcare Ministerial Assurance Group, feeding in some of the key developments and priorities from the NHSFV service.

The following points were made in discussion:

(i) Members gave their congratulations in respect of the excellent progress and performance in relation to Freedom of Information request responses.

(ii) A question was asked in relation to the Strategic Diagnostics Review. The aim was to look at a future Target Operating Model in diagnostics which would make the most of the resources available in the system. A Strategic Needs Assessment would be undertaken to understand capacity and demand. This was a significant piece of work covering many specialities. The target was to have the Strategic Needs Assessment complete by the end of this financial year. The work would feed into the sub-national planning arrangements going forward and there would also require to be consideration of how to enable a Once for Scotland model.

(iii) The Board sought an update on the sub-national arrangements. Work was underway with workstreams now running. The Flow workstream was working on urgent and unscheduled care arrangements. This work would build on previous learning such as from the Discharge Without Delay programme. Work was also progressing in relation to finance and workforce planning and planned care.

Each group had met once so far to undertake exploratory sessions. Initial plans required to be signed off by Boards before the end of the financial year.

The Forth Valley NHS Board noted the report.

Committee Minutes

7.1 Audit & Risk Committee – Verbal Update from meeting of 23 January 2026

In the absence of the Chair, Mr Urquhart provided a verbal update on the meeting of 23 January 2026 noting that the Committee had received the Internal Control Evaluation report along with an update from External Audit on the plan for the 2025/26 audit process.

The Forth Valley NHS Board noted the verbal update on the meeting of the Audit & Risk Committee of 23 January 2026.

7.2 Clinical Governance Committee – 11 November 2025

Key items had previously been highlighted at the November Board meeting. The minute was commended to the Board for noting. A verbal update was also provided on the meeting of 13 January 2026.

The Chair of the Committee, Mr Stuart, noted that the Committee had made changes to its planner to focus on whole system governance. The Committee had considered the annual organ donation update, the HIS Maternity Inspection Report and Action Plan. The risk profile of delivering TTG and would receive a public protection report in March.

Further information was sought on gaining acute directorate assurance through data and qualitative information. Reporting tended to be data heavy to provide firm evidence when change was being seen in the system. However, it was acknowledged that qualitative information was also required.

The Forth Valley NHS Board noted the minute of the Clinical Governance Committee meeting of 11 November 2025 and the key issues from the verbal update on the meeting of 13 January 2026.

7.3 Staff Governance Committee – 18 November 2025

Key items had previously been highlighted at the November Board meeting. The minute was commended to the Board for noting. A verbal update was also provided on the meeting of 20 January 2026.

The Chair of the Committee, Mr Fairbairn, noted that the Committee was assured the HR processes were working well with exceptions around absence, PDPR and some mandatory training. A revised action plan had been requested to include timelines and how the actions would impact on performance. There was also consideration of cultural indicators and moving the Culture work into Business as Usual.

The Forth Valley NHS Board noted the minute of the Staff Governance Committee meeting of 18 November 2025 and the key issues from the verbal update on the meeting of 20 January 2026.

7.4 Strategic Planning, Performance & Resources Committee (SPPRC) – 16 December 2025

The Forth Valley NHS Board received the Strategic Planning, Performance & Resources Committee Minute of the meeting held on 16 December 2025. The minute was commended to the Board for noting.

The Chair of the Committee, Ms Mahal, highlighted that the Committee had concerns relating to the time taken to resolve the National Treatment Centre building issues. The Committee had considered the Shifting the Balance of Care evaluation and commented on the Anti-Racism Plan, which would be presented to the Board in February for approval.

There was discussion on the GP Walk-in service proposal submitted to the Scottish Government. Initial feedback had been received and discussions were ongoing.

The Forth Valley NHS Board noted the minute and key issues highlighted from the Strategic Planning, Performance & Resources Committee meeting of 16 December 2025.

Advisory Committee Minutes:

7.5 Area Clinical Forum (ACF) - 13 November 2025

Key items had previously been highlighted at the November Board meeting. The minute was commended to the Board for noting. A verbal update was also provided on the meeting of 15 January 2026.

Ms Cassells, ACF Chair, highlighted that the Forum had considered the draft Anti-Racism Plan. A flash report template had been developed to share successes. A treatment threshold proposal had been approved following an update from the Area Dentistry Committee.

An update was sought on evaluation of the Sunday Pharmacy Opening pilot. The Pilot was running until mid-February. There would then be an evaluation of the access, conditions presented, patient and pharmacy feedback.

Following a question, the Board was advised that work continued in relation to engagement with the Area Medical Committee and that an update would be considered by the ACF at its next meeting and thereafter, reported to the Board.

The Forth Valley NHS Board noted the minute of the Area Clinical Forum meeting of 13 November 2025 and the key issues from the verbal update on the meeting of 15 January 2026.

7.6 Area Partnership Forum – 16 December 2025

A verbal update was also provided on the meeting of 16 December 2025.

Mr Clark, APF Chair, highlighted that due to extreme operational pressures at the time of the meeting a reduced agenda had been considered. The implementation of the Reduced Working Week was on track.

The Forth Valley NHS Board noted key issues from the verbal update on the meeting of 16 December 2025.

7.7 The Minute of Clackmannanshire & Stirling Integration Joint Board – 24 September 2025 and Directions were noted for information.
Assurance was sought and provided on the implementation of the Direction. Clarity was sought on the monitoring of the Alcohol and Drug Partnership (ADP), and assurance was provided that the best way of overseeing and monitoring of this service, alongside other services delegated to the IJB was under consideration by SLT to ensure the NHS Board also had appropriate oversight.

7.8 The Minute of the Falkirk Integration Joint Board – 31 October 2025 was noted for information.

8 Strategic Risk Register Update: December 2025 – January 2026
The Forth Valley NHS Board considered a report for approval, presented by Miss Webb which provided an update on the Strategic Risk Register for the period of December 2025 to January 2026.

Key messages in the report included:
(i) All current strategic risks had been reviewed and remained static bar SRR009 which had decreased in risk score.
(ii) One Focused Review had been conducted in the reporting period: SRR005: Financial Sustainability.
(iii) There was an improvement to the appetite profile of the Board for the reporting period. There were 0% of risks within the Boards appetite, 33% within the Board's tolerance and 67% outwith the Board's appetite and tolerance.
(iv) There were no overdue actions or emerging risks/hotspots to note for the reporting period.

The following points were made in discussion:
(i) Members asked if the Short Life Working Group on Risk, comprising NXD membership, had sufficient support and resource in light of the expanded remit and increased asks on it. There would be discussion of the balance of resource at the next meeting of the SLWG in light of the additional asks on the group.
(ii) Clarity was sought on the Primary Care Sustainability Board and whether this had met. It was confirmed that the Primary Care Sustainability Board had had its first meeting and was at a formative stage. An update would be provided to the March meeting of the Strategic Planning, Performance & Resources Committee to update on its work.
(iii) A question was asked on where the risk reporting of the Urgent and Unscheduled Care Action Plan was aligned to. The Medical Director was Chair of the Urgent and Unscheduled Care Programme Board where risk was a standing item, and the Head of Risk Management was a member. The detail of the plans as reported to the Programme Board were much more extensive. There would be consideration at the SLWG on having the right balance of information at the right places.
(iv) There were comments that movement in the risk scores was positive and evidenced that the risk system was effective.

The Forth Valley NHS Board:
(1) approved the changes to the Strategic Risk Register for the reporting period;
(2) noted the progression of the mitigating actions identified;
(3) noted the update on the focused reviews conducted within the period;
(4) noted the progress made by the Short Life Working Group, and

(5) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action

(i) Provide an update on the Primary Care Sustainability Board's work at the March SPPRC meeting. — Gail Woodcock

9. Update on Safety

(a) Quality and Assurance Report

The Forth Valley NHS Board considered a report for assurance, presented by Mr Murray which provided an overview of the current position in relation to quality assurance and progress across key priorities in quality and safety.

The key messages in the report included:

(i) Further work was ongoing to improve the Significant Adverse Event Review (SAER) process. The improvement plan focused on timely reporting, early escalation, panel formation, and shared learning and further resources to address issues were being considered through a business case.

(ii) Significant improvement was demonstrated in Complaints Management with a 50% reduction in open complaints. An improvement plan had been implemented to reduce the stage 2 complaints backlog since August 2025.

(iii) To mark its success there was a Safer Together Celebration Event. The Breakthrough Series Collaborative demonstrated strong system-wide progress in patient safety through a quality improvement approach. A full programme evaluation would be considered by the Clinical Governance Working Group in February 2026.

(iv) Healthcare Improvement Scotland (HIS) carried out two unannounced Safe Delivery of Care - (SDC) inspections covering the acute Mental Health Unit and Maternity Services. As part of the inspection process comprehensive evidence submissions were provided. The SDC Maternity report identified nine areas of good practice, two recommendations, and eleven requirements. The Acute Mental Health report was due to be published by HIS on 28 January 2026. Inspection Oversight Groups had been established to lead and monitor the delivery of actions in response to the recommendations and requirements from both reports.

The following points were made in discussion:

(i) Members recognised that the SAER process was high quality with learning summaries of value produced with an aim to support families. However, members raised concerns that urgent improvements were needed in terms of timing and concluding SAERs without impacting on quality and requested that a clear action plan with appropriate resourcing was provided to Board members for assurance. The timeline being provided was not acceptable and required to be brought forward. A question was asked seeking assurance on the implementation of actions from Learning Summaries including that this went system wide.

(ii) Members agreed that an increased focus on SAER would be appropriate. Members were advised that resource may have to be redirected to support SAERs and a potential consequence would be to consider the impact on Patient Safety Conversation Visits (PSCVs). Board Members raised concerns about this approach. PSCVs were key for Board Members in connecting with frontline staff and there needed to be a balanced approach. The Board Chair

agreed to have further discussions outside the Board meeting, given the importance of PSCVs on how they are run and who needed to be involved.

(iii) A question was asked on whether issues around specialist clinical input into SAERs had been addressed. Some SAERs required input from external specialists, for example in Maternity and there was limited influence which could be exerted over this. However, locally all specialists had been trained in the SAER process and were part of a pool who could be drawn on. Further, the Medical Director had communicated to consultants an expectation that SAER involvement was prioritised and that this was a core part of their professional practice.

(iv) Assurance was sought on the new structures being put in place following the end of the Safer Together Collaborative. The Safer Together Collaborative evaluation would be considered by the Clinical Governance Working Group and members noted that the Collaborative had been very positive and successful.

(v) The improvement in cardiac arrest was welcomed. Members asked what had led to the improvement and what learning could be taken from this for other areas. There was a faculty which oversaw improvement aims and monitored performance on the ground. Decision making had been done well and the collaboration approach for other areas would be considered.

(vi) There was a question on how connected SAERs, complaints and PSCVs were with the internal control environment. The new Quality and Safety steering group learning system had good integration with the Risk Management team with issues being outlined and connections made.

(vii) Members asked if there were any areas of focus from the Safer Together Collaborative which were not being picked up by the Quality and Safety Steering Group. It was confirmed that all measures had been pulled in as these were national measures. There would be focus to sustain the improvements made in quality.

(viii) There was discussion on the value of having a single safety dashboard which considered qualitative and quantitative information.

(ix) Clarity was sought on the consideration of complaints themes and how any problematic areas were identified and addressed. Thematic information was reported to the Clinical Governance Committee through the Patient Centred Care reporting. There was a desire to have thematic reporting at unit level as part of the plan. It was agreed that the thematic report would be shared with Board Members.

(x) It was highlighted that the upcoming Quality Board Seminar would consider many of the issues raised in discussion and seek to refine what performance monitoring information was appropriate at Board level and what would be dealt with at Committee level.

The Forth Valley NHS Board:

(1) reviewed the key areas of Quality and Safety contained within the report, noting the areas of progress and risk;

(2) agreed that further assurances were required around the actions, resourcing and timeline to deal with the backlog of SAERs, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Actions

(i) Include consideration of performance reporting and a quality dashboard at the Board Seminar. — Andrew Murray/Karen Goudie

(ii) Circulate the Patient Centred Care Report to Board.
(iii) Provide further information to Board members on the action plan for SAERs, to include resourcing information and a revised trajectory timeline for dealing with the backlog.

Jack Frawley
Andrew Murray

(b) Healthcare Associated Infection (HAI) Report December 2025

The Forth Valley NHS Board considered a report for assurance, presented by Mr Horwood, which was a mandatory reporting tool for oversight of HAI targets and other activities.

Key messages in the report included:

(i) Total SABS remained within control limits. There were two hospital acquired SABs in December.
(ii) Total DABs remained within control limits. There were three hospital acquired DABs in December.
(iii) Total CDIs remained within control limits. There were two hospital acquired CDIs in December.
(iv) Total ECBs remained within control limits. There were three hospital acquired ECBs in December.
(v) There were four mandatory surgical site infections in December.
(vi) There was one outbreak reported in December.

The following point was made in discussion:

(i) The Board commented that this report was extremely valuable and gave strong assurance, recognising that due consideration had been undertaken at the Clinical Governance Committee.

The Forth Valley NHS Board:

(1) noted the HAIRT report;
(2) noted the performance in respect for SABs, DABs, CDIs & ECBs, and
(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

The Board adjourned at 11.20am and reconvened at 11.35am with all members present as per the attendance list.

10. HIS Unannounced Maternity Inspection-NHS Forth Valley

The Forth Valley NHS Board considered a report, presented by Professor Goudie, which provided an update on the unannounced Safe Delivery of Care inspection of Maternity Services at Forth Valley Royal Hospital on 25 and 26 August 2025.

Key messages in the report included:

(i) The HIS report was published on 27 November 2025 identifying:
- 9 areas of good practice
- 2 recommendations
- 11 requirements

(ii) NHS Forth Valley subsequently provided HIS with an action plan addressing the recommendations and requirements. A more detailed local action plan had also been developed to ensure that actions to address the recommendations and requirements were progressing to expected timescales.

(iii) The key matters identified in the HIS report related to:

- **Triage:** Maternity Triage processes and timely access were highlighted.
- **Induction of Labour:** Time to induction of labour reviewed.
- **Adverse Events Process:** Oversight, categorisation of events, escalation and reporting.
- **Workforce Governance:** Staffing escalation processes and protected leadership time.
- **Training Compliance:** Mandatory training reviewed across a number of themes.

The following points were made in discussion:

(i) The Board sought further assurance that there was compliance with all requirements and recommendations and asked if any items were offtrack. The Safe Delivery of Care Group met every two weeks and provided assurance on the delivery of actions, which were all on track. Significant improvements had been made. In terms of workforce governance changes to the process had already been made. There had been over-recruitment and no risks identified at the moment. The Group would move to four weekly meetings in recognition of the pace of improvements.

(ii) Members noted that key themes included mandatory training and PDP compliance being at low levels, a question was asked if this was Maternity specific or system wide due to pressures. In terms of the transferability of learning the Chief Nurse and Directors had come together to look at this and triangulate for Acute Services. The PDP and mandatory training findings were reflected more widely in the organisation.

(iii) A question was asked on the next steps in relation to re-inspection. There would be a follow up inspection from HIS but this would be unannounced.

(iv) Members asked whether HIS provided commentary on the action plan. There was a process of assurance conversations and factual accuracy checking. The report was written at a high level and locally there was then work to translate the findings into an action plan.

(v) The Board highlighted that the inspection findings also included a number of significant positives including the culture in Maternity Services and that this should not be lost amongst the improvements required. Discussion took place on the impact on staff and how they were being supported.

(vi) Members asked if staff had seen the report and been engaged in the implementation of the actions. It was confirmed that this had been done.

(vii) There was a question on whether the findings would have a material impact on the risk profile. It was noted that this was already recorded at various levels.

(viii) Board members discussed how they could be assured that processes were in place to identify issues without the need to await formal inspections. It was noted that work was already underway to consider any improvements that could be made to existing audits and processes.

The Forth Valley NHS Board:

(1) noted the findings of the HIS inspection and associated risks;

(2) noted the proposed action plan addressing HIS recommendations, including governance, workforce, and safety improvements;

(3) noted that the Clinical Governance Committee would oversee the implementation of the Action Plan, and

(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of

objectives and where improvements were needed, clear actions had been identified.

11. Spotlight on Services - Specialist Rehabilitation Service

The Forth Valley NHS Board considered a report, presented by Professor Goudie, which provided an overview of the Specialist Rehabilitation Service (SRU). The Board viewed a video story on the Service. Craig Finlayson and Linda Stevenson were in attendance and provided a presentation on the work of the service.

Key messages in the report and presentation included:

(i) The Service had been established in 2020 following funding from the Scottish Major Trauma Network, allocated to every Health Board, to strengthen rehabilitation pathways for people recovering from major trauma.

(ii) The Service operated through a multidisciplinary team comprising nurses, nursing assistants, physiotherapists, occupational therapists, speech and language therapists, dietitians, therapy assistants, and neuropsychologists, with additional input from rehabilitation consultants, pharmacists, psychiatrists, and orthotists when required.

(iii) The service had demonstrated major system-wide benefits. Since 2021, the SRU had generated an estimated £442,000 per week in avoided care costs—equivalent to approximately £23 million annually - largely due to improved rehabilitation outcomes reduced length of stay and fewer out-of-area placements.

The following points were made in discussion:

(i) Members asked why the most recent year had been the busiest to date. The launch of the website was noted and a general increased awareness with acute colleagues which was the likeliest cause of the increase.

(ii) A question was asked as to whether 10 beds were enough for the unit, particularly whether demand met resource or if hard decisions were required. The service was working well at the moment. There was not a significant waiting list. The importance of in-reach was noted and through assessment the unit was used at the right time for the right patients. Some services were delivered in the acute setting.

(iii) Members asked if there was an ability to shift some rehabilitation work to patient homes. The service was focused on in-patient rehabilitation and not everyone could manage at home. The length of stay in the unit had reduced year on year. The transition service would reduce the length of stay further. There could be further evolution and there was impact through acute in-reach.

(iv) The Board recognised that other Boards had tried this nurse/AHP led model and it had not been as successful as the local service. The hard work of staff locally was praised in this regard.

(v) Members asked if there were any live risks which would be captured in the review. It was noted that the service would be looked at as a whole, including the staffing model to ensure this was right. The funding stream would also be evaluated to ensure it was right for the service.

The Forth Valley NHS Board:

(1) noted what specialist rehabilitation was, the multidisciplinary service being provided and the positive outcomes for FV patients and their families;

(2) noted the data highlighting whole system clinical effectiveness and the estimated cost avoidance generated by the impact of the specialist rehab service;

(3) commended the Team for their work and asked for their appreciation to be passed to the service user for sharing their powerful experiences of the service with the Board, and

(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

12. Whistleblowing Standards & Activity Report

The Forth Valley NHS Board considered a report for assurance, presented by Professor Goudie, which provided an update on Whistleblowing activity in NHS Forth Valley.

Key messages in the report included:

(i) To date NHS Forth Valley had received a total of 26 cases. 10 of these were managed under Stage 1 of the Whistleblowing procedure and 16 cases under Stage 2 of the procedure.

(ii) To support the Speak Up Service and Whistleblowing Arrangements there were Speak Up Advocates and Confidential Contacts available to provide a confidential, impartial service where employees could discuss concerns in a safe space or speak to someone in confidence for support and advice. The roles of the advocates and confidential contacts were combined to support both the Speak Up and Whistleblowing processes.

(iii) NHS Forth Valley participated in National Speak Up Week, which took place between 29th September and 3rd October 2025. The theme was “Listen, Act, Build and Trust”.

The following points were made in discussion:

(i) The Board’s Whistleblowing Champion noted that a new INWO had been appointed and had met with the national network in January.

(ii) The report had been considered by the Staff Governance Committee who had been assured by the information presented.

(iii) Members asked if there were ways of knowing if staff trust in the processes was increasing. There had been extensive communications related to whistleblowing and speak-up and there would continue to be more work undertaken in improving staff trust. The annual iMatter survey included a question on this with 80% of respondents advising they were happy to raise an issue through the process. It was still a relatively new process having been launched during Covid and the communications work would continue. Board members were advised that these metrics were being considered as part of the Culture work.

(iv) It was commented that if matters reached whistleblowing, then that showed other processes had failed. There were a number of other mechanisms which were utilised frequently and resolved matters.

The Forth Valley NHS Board:

(1) noted Whistleblowing performance in NHS Forth Valley in Quarters 2 and 3 of 2025/26, and

(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

13. Finance Report

The Forth Valley NHS Board considered a report for approval, presented by Mr Urquhart, which provided an overview of the month nine financial results and an updated forecast outturn for the year.

Key messages in the report included:

(i) Following a detailed review of the Quarter 3 financial results, alongside an updated assessment of savings delivery, confirmation of funding allocations, and favourable revisions to financial planning assumptions, the forecast year-end position had improved to break even.
(ii) Achievement of a break-even position remained subject to risk in the final quarter, particularly in relation to confirmation of IJB outturns.
(iii) The financial planning process for 2026/27 was underway with the final version to be considered by the Board in March.

The following points were made in discussion:

(i) Members noted that supplementary staffing had decreased and asked if there were any other factors aiding the improved financial position. In terms of delegated functions there were close working relationships with partners and NHS Forth Valley had included a risk share contribution upfront in the financial plan. Investment in substantive staff had helped to reduce supplementary staff costs.
(ii) Comments were made that the diligent financial stewardship approach across and by the whole organisation had delivered the position the Board was now in. The improvement in the acute position was one factor which contributed to projecting breakeven, along with medicine rebate, workforce costs and less temporary staffing usage over winter.
(iii) Members also discussed the timeline for considering the approval processes for the Financial Plan for the next 3 years.

The Forth Valley NHS Board:

(1) noted the break-even position against both revenue and capital sources projected for 2025/26 subject to identified risks in the final quarter which represented an improvement on the previously reported position;
(2) noted the ongoing work in relation to financial planning with an updated 3-year financial plan to be presented to the Board seminar in February followed by Board approval in March, and
(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

14. Performance Report

The Forth Valley NHS Board considered a report for assurance, presented by Ross McGuffie which provided an update on performance against a range of national and local measures.

Key messages in the report included:

(i) Performance Summary.
(ii) Area of Focus – Urgent & Unscheduled Care.
(iii) Performance Report: Priority Areas of Performance.
(iv) Performance Scorecard.

The following points were made in discussion:

(i) Information was sought on how the Criteria to Reside had been received clinically. Criteria to Reside comprised 6 questions and linked to how wards were run. Clinicians had been involved and there were uniform ward rounds. No negative feedback had been received. It had been recognised by clinicians that this was how the services needed to work. The length of stay had been reduced and although it required consistent focus, it kept the flow going through the site.

(ii) Comments were made on the improvements in collaborative working with the health and social care partnerships and on the excellent performance through the peak winter pressures of December.

(iii) Members noted that although the headline statistics showed little movement there was a different feel to performance. A question was asked on what impact was made by the introduction of the third CT scanner. The additional capacity had helped to deliver a projection that wait times would be on track by year end.

(iv) There were comments on the performance of Psychological Therapies in delivering treatment to 77% of patients within 18 weeks of referral. The total wait list had been brought down, however there were challenges with the backlog of long waits through a combination of historic demand and workforce reduction. Supplementary staffing was not used. Long waits were realigned to areas of the service with capacity where that was appropriate. The Interim Director of Psychology would keep focus and leadership on this. Through the implementation of the reduced working week approximately 130 less patients could be seen each year.

(v) It was noted that communications with staff side had been excellent through the winter period and that staff morale is boosted when using fewer contingency beds.

(vi) There were meetings with the Centre for Sustainable Delivery every two weeks. The work was ongoing in relation to the clinical model. The rosters and patient cohorts had been reviewed with output from this expected soon. Performance locally during the day was good but dropped slightly at night when there were less clinical decision makers available. 3 senior decision makers had been recruited in the short term with longer term recruitment processes ongoing. Additional funding from slippage to the HSCP had also helped flow. Members reiterated the importance of focus on Urgent and Unscheduled Care performance to make improvements.

The Forth Valley NHS Board:

(1) noted the latest performance data and the Area of Focus – Urgent & Unscheduled Care and Priority Areas of Performance;

(2) noted the progress made in reducing the number of patients waiting over 52 weeks for a new inpatient appointment and for an inpatient/day case procedure, and

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

15. Schedule of Business

The Forth Valley NHS Board **noted** for information the Schedule of Business which would be updated to reflect the meeting dates and business which had been realigned.

16. Any Other Competent Business

There was no other competent business.

17. Risks and Reflections
The Forth Valley NHS Board resolved that there were no matters to recommend that the Senior Leadership Team consider to be included in the Strategic Risk Register.

18. Date and Time of Next Meeting: Tuesday 24 February 2026 at 9.30am.

19. Business Taken in Private Session
In terms of section 5.22 of the Code of Corporate Governance, the Board resolved into private session on the grounds that the subsequent items of business related to commercial interests of another person and confidentiality was required.

4. Action Log
Forth Valley NHS Board – 24 February 2026

NO.	DATE OF MEETING	AGENDA TOPIC / ITEM	ACTION	LEAD	TIMESCALE	COMMENT / PROGRESS	STATUS
070	28.01.25	Integration Schemes	An update on any Ministerial feedback received.	Jillian Thomson / Ross McGuffie	28.04.26	The Falkirk Integration Scheme was approved by Board on 28 January and subsequently by Falkirk Council at its meeting on 30 January 2025. Comments were received from Scottish Government and further drafting work is progressing. The C&S Integration Scheme was approved by Board on 28 January and subsequently Stirling Council at its meeting on 6 February 2025. The dispute resolution process regarding the C&S Scheme is ongoing and making positive progress.	In progress

114	25.11.25	Corporate Parenting	Ensure all independent contractors are aware of their responsibilities in relation to corporate parenting.	Jilly Taylor	10.02.26	Independent contractors are made aware of their responsibilities and have access to the Turas e-learning module, uptake of which is strongly encouraged.	Complete
116	27.01.26	Strategic Risk Register Update: December 2025 – January 2026	Provide an update on the Primary Care Sustainability Board's work at the March SPPRC meeting.	Gail Woodcock	31.03.26	A report is being prepared for the March meeting of the SPPRC. The Primary Care Programme Board has now commenced. It is chaired jointly by the Chief Officer, Falkirk IJB and Depute Medical Director for Primary Care. The Terms of Reference include reference to the Board's and IJB's strategic risk on primary care sustainability.	In progress
117	27.01.26	Quality and Assurance Report	Include consideration of performance reporting and a quality dashboard at the Board Seminar.	Andrew Murray / Karen Goudie	03.03.26	Consideration of this matter will be undertaken at the March Board Seminar.	In progress
118	27.01.26	Quality and Assurance Report	Circulate the Patient Centred Care Report to Board.	Jack Frawley	24.02.26	The report was circulated to Board Members.	Complete
119	27.01.26	Quality and Assurance Report	Provide further information to Board members on the action plan for SAERs, to include resourcing information and a revised trajectory timeline for dealing with the backlog.	Andrew Murray	28.04.26	Information will be provided to the Clinical Governance Committee and shared with Board Members.	In progress

STATUS:
Overdue
In progress
Complete

FORTH VALLEY NHS BOARD
Tuesday 24 February 2026

5(b). Highlight Report on Board Seminars
For: Information

Executive Sponsor: Kerry Mackenzie, Acting Director of Strategic Planning & Performance
Author: Jack Frawley, Board Secretary

Executive Summary
Board Seminars are held bi-monthly and provide an opportunity for members to consider issues in detail, allowing for development of understanding of strategic issues. The format of the sessions usually consists of a presentation or briefing from Executive Directors and managers leading the area of work, or staff involved in the work, followed by discussion and questions from members or a workshop focused on areas for board development.

Board Seminars are not decision-making meetings. The Seminars can, however, assist the decision-making process through in-depth exploration and analysis of a particular issue which will at some point thereafter be the subject of a formal Board decision. These sessions also provide an opportunity for updates on ongoing key issues.

Recommendation
The Forth Valley NHS Board is asked to note the report for information.

Key Issues to be Considered
The Board Seminar on 10 February 2026 was held in person at Carseview House, Stirling and attendees included Board members and members from the Senior Leadership Team.

The Seminar covered three topics:

- Draft Financial Plan 2026/27 Update
- Corporate Objectives 2026/27 Update
- Corporate Parenting Training provided externally by Who Cares? Scotland

Board Members had the opportunity to discuss and influence the Board's approach to the Draft Financial Plan and draft Corporate Objectives.

The afternoon session was dedicated to Corporate Parenting training which was provided by Who Cares? Scotland - Scotland's only national independent membership organisation for Care Experienced people.

NHS Forth Valley

Forth Valley NHS Board

6. Board Executive Report
Purpose: This report is for Noting

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Ross McGuffie, Chief Executive

Executive Summary

This report provides an opportunity to deliver a regular wide update from the Board's Executive Team, covering celebrating success; general updates; inspection activity; visible leadership; and horizon scanning.

Action Required

The Forth Valley NHS Board is asked to:
(1) note the contents of the report.

Governance Route to the Meeting and Previous Board Consideration

The Board Executive Report is a standing item at Board meetings, providing an opportunity to update the Board on key issues.

Risk Assessment and Mitigation

No risk assessment has been undertaken on this update report.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications

There are no financial implications within this update report.

Workforce Implications

The report details a range of positive development for staff wellbeing, including celebrating success, staff engagement and visible senior leadership.

Quality / Patient Care Implications

This report outlines inspection activity currently underway within the Board but has no implications around quality of care.

Population Health & Care Strategy

This report will include regular updates on key successes and developments around the population health strategy implementation.

Climate Change / Sustainability Implications

There are no sustainability implications within this update report. .

Engagement and Communications

Was statutory engagement with stakeholders required? Yes ☐ No ☒

Appendices
Appendix 1 – Main Report

Appendix 1

1. Celebrating Success

1.1 Celebrating success is an essential part of reinforcing positive outcomes, enhancing staff morale and strengthening commitment to our organisational values. Recognising the great achievements of our dedicated workforce helps foster a positive culture, encourage collaboration and remind both staff and Board Members of the great impact we have on the population of Forth Valley.

1.2 Since the last Board meeting, there have been a number of positive areas of success, including:

- An article has recently been published in the BMJ Leader on the FVRH's national **Simulation Centre**, providing great recognition of the innovative use of simulation not only for education, but also for engaging with emotionally charged challenges, enabling system-wide reflection and co-designing new models of care.

- Neil Gray is also due to attend the launch of our local **Macmillan Improving the Cancer Journey** programme in Forth Valley which will take place at the University of Stirling on 25 Feb, highlighting the services and support available including the Macmillan one-to-one service which has been in place for several years.

- The Chief Executive of NHS Scotland visited the **Acute Frailty Unit** at FVRH to meet staff members and to hear how the service provides early access to comprehensive geriatric assessments, using a multidisciplinary and holistic approach to help identify each patient's individual goals.

- Teams which have just been confirmed as finalists in this year's **RCN Scotland Nurse of the Year Awards** in the Nursing Team of Year category (the winners of each category will be announced at an awards ceremony on 30 April at the National Museum of Scotland in Edinburgh)
  1) NHS Forth Valley Prison Health Care Teams – three national prisons
  2) Specialist Rehabilitation Unit, Bellfield Centre, Stirling Health and Care Village, NHS Forth Valley

2. General Updates

2.1 Since the last Board meeting, there have been a number of developments of note:

- As part of the roll out of **Value Based Health and Care**, Information Services have been instrumental in creating important tools and datasets that will help us to better understand the Forth Valley patient population to create more targeted and successful interventions, guided by reliable evidence.

- Management nominations are now open for a place at the **NHSFV Leadership Event** on 2nd April, 2026. The event is open to anyone employed in NHSFV who wants to connect with others, explore new ideas and lead with confidence across all levels of the organisation.

- A **Research and Innovation Collaboration session** is being held on 5th March 2026 to help overcome obstacles to collaboration, followed by dynamic five-minute pitches presented by partners across our network to inspire new opportunities and connections.

- NHSFV is implementing an updated **Intrathecal (Spinal) Opioid Protocol** to enhance patient safety and ensure early identification of opioid-related adverse effects. Intrathecal opioids—commonly morphine and diamorphine —provide excellent postoperative analgesia, but carry a known risk of delayed respiratory depression. The revised guidance reinforces that careful, structured monitoring is essential, particularly during peak-risk windows.

3. Inspection Activity

3.1 Since the last Board meeting, there has been ongoing activity around:

- The HIS inspection report around **Mental Health Services** reported at the end of January. The report observed staff treating patients with compassion, but noted the need for strengthened risk assessment, clearer assurance processes, staff governance and environmental improvements. An action plan has been developed to ensure all improvements identified are implemented in a timely manner, with oversight from the Clinical Governance Committee.

- A **national review into group-based child sexual abuse and exploitation** commenced on 9 February 2026. This is following a ministerial request in December 2025. The review will be led by the Care Inspectorate and His Majesty's Inspectorate of Constabulary in Scotland (HMICS), working with Healthcare Improvement Scotland (HIS) and His Majesty's Inspectorate of Education in Scotland (HMIE) and other scrutiny bodies as appropriate. Chief Officers' Groups are requested to facilitate the provision of information and supporting evidence regarding how each of the 32 local authority partnership areas recognise, identify, assess and respond to incidences of group-based child sexual abuse and exploitation and group-based child criminal exploitation. The review commences in February and aims to publish the phase 1 report in late August 2026.

4. Visible Leadership

4.1 In line with the Board's culture programme, the Executive Team are programming regular walk rounds and visits to provide an opportunity for positive engagement with staff. This programme aims to make it easier for staff to raise concerns or ideas with senior staff, foster a culture of collaboration and allow leaders to set a positive example, demonstrating commitment to our organisational goals and values.

4.2 Visits include:

- Mental Health Unit
- Cardiology
- Visit to ED with Christine McLaughlin
- Clinical shifts by Medical Director
- Outpatients department
- Women & Children
- Meeting with the Promise Implementation Team (Service Area Visit)
- Falkirk Council Long Services and Employee Recognition Event

5. National and Regional Developments

5.1 The Board Executive Team have a number of lead national and regional roles, with updates as follows:

- The Director of Public Health has been working closely with national colleagues in support of the new Sub-National Planning Committees, with the aim of ensuring a population health focus across the four key workstreams set out within the Director's Letter.

6. Horizon Scanning

6.1 Moving forward, Board members can anticipate further updates around the following areas of activity:

- The Cabinet Secretary announced a new Director's Letter (DL) on 13th November, setting out arrangements for new sub-national planning structures, with NHS Forth Valley sitting within the West of Scotland Sub-National Planning Committee. Several senior leads from NHSFV are actively engaged within the current working groups, with the aim of compiling early plans before the end of the financial year.

7.1 Minute of the Audit & Risk Committee Meeting held on Friday 23 January 2026
For: Assurance

Minute of the Forth Valley NHS Board Meeting held remotely on 23 January 2026

Present: Fiona Collie (Chair)
Robert Clark (Non-Executive Director)
Martin Fairbairn (Non-Executive Director)
Stephen McAllister (Non-Executive Director)
Finlay Scott (Non-Executive Director)

In Attendance: Jack Frawley (Board Secretary)
Jocelyn Lyall (Chief Internal Auditor)
Kerry Mackenzie (Acting Director of Strategic Planning, Performance & Resources)
Rebbecca McConnachie (Deloitte)
Ross McGuffie (Chief Executive)
Anne Marie Machan (Internal Audit Manager)
Neena Mahal (Board Chair)
Sarah Smith (Corporate Services Assistant - Minute)
Scott Urquhart (Director of Finance)
Vicky Webb (Head of Risk Management)

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1. Welcome, Apologies for Absence and Confirmation of Quorum
The Chair welcomed all present to the meeting and confirmed the meeting was quorate.

There were no apologies. Jim Boyle, Deloitte was not in attendance.

2. Declarations of Interest
There were no declarations of interest.

3. Minute of the Audit & Risk Committee Meeting held on 31 October 2025
The minute of the meeting held on 31 October 2025 was **approved** as a correct record, subject to point (v) in Key Messages in the Report at item 8 being moved to item 6.

4. Matters Arising from the Minute / Action Log
The Committee noted that actions 24, 25, 26, 27, 28a, 29d, 30, 31 and 32 were marked as complete and would be removed from the action log.

The following updates were provided against in progress actions:
28b – the action remained in progress pending the commencement of planning for the 2026/27 audit cycle. It was confirmed that the action would remain open until planning work had been concluded.

29a – although work had progressed, completion would not be achievable within the original timeframe. A revised completion date of March 2026 was agreed by Committee to align with the associated policy development process.

The Committee was advised that the actions related to senior leadership team follow-up had now been completed. The Committee agreed to remove actions 29b and 29c from the action log.

The Audit & Risk Committee noted the Action Log.

5. Internal Control Evaluation 2025/26

The Committee considered a report for assurance, presented by Jocelyn Lyall, which provided the Internal Control Evaluation report as an appendix.

Key messages in the report included:

(i) Overall, the ICE provided Reasonable Assurance on the sufficiency of governance arrangements to support delivery of organisational objectives. There were 14 findings, including one significant relating to the currency of clinical policies.

(ii) The Committee noted the organisation's de-escalation to Stage 2 of the NHS Scotland Support and Intervention Framework, recognising this as evidence of strengthened governance, culture, and executive leadership during the year.

(iii) Key governance areas—clinical governance, staff governance, financial governance, and information governance—were reviewed, with the evaluation highlighting progress in whole-system assurances, continued pressure in adverse event and complaints performance, strong workforce-related assurance, transparent financial reporting, and significant improvement in FOI compliance.

(iv) The Committee noted that national policy developments, including the Population Health Framework 2025 and Health & Social Care Service Renewal Framework, presented opportunities and challenges for future planning; the evaluation also reflected positively on progress with transformation programmes, corporate objectives, and risk management.

The following points were made in discussion:

(i) Members queried whether the Internal Control Evaluation was intended as a six-monthly consolidated summary or a review of recent audit findings. The ICE served both roles, providing mid-year governance assurance while also capturing recent developments across the audit programme.

(ii) A question was asked on how many audits underpinned the review and where these were reflected. Internal Audit advised that each governance section contained summaries of relevant audits and that the evaluation complemented, rather than replaced, detailed audit reports.

(iii) Concerns were raised about the length of the report and the inclusion of descriptive narrative within both the executive summary and main sections. This feedback was acknowledged and it was noted that there would be ongoing refinement to the structure of the report which would be seen in future iterations.

(iv) Items for Consideration in the Internal Control Evaluation would be reviewed to confirm whether actions were required. Any necessary items would be incorporated into the internal audit follow-up process.

(v) Members sought clarification regarding the backlog of clinical policies and the visibility of the SEAR improvement plan. It was confirmed that both matters were subject to active scrutiny through the Clinical Governance Committee, with associated improvement work underway.

(vi) Questions were raised on whether internal audit activity provided sufficient operational insight in areas where Board members lacked direct visibility. Internal Audit confirmed that the 2026/27 planning cycle would include greater

Board involvement to ensure appropriate balance between governance-level assurance and operational reviews.

(vii) There was discussion in relation to the level of staff resource available. Where resource pressures required changes to the internal audit plan, Internal Audit would risk assess the options with management and return to the Committee for formal approval.

The Audit and Risk Committee considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and, where improvements were needed, clear actions had been identified.

Action:

1. The Adverse Events Improvement Plan to be circulated to Committee. **Jack Frawley**

6. Internal audit Progress Report – January 2026

The Committee considered a report for assurance, presented by Anne Marie Machan, which provided an update on progress with the 2025/26 internal audit plan since the October 2025 meeting and an update on Internal Audit activity.

The following key points were noted:

(i) Since the October 2025 Audit & Risk Committee meeting, the focus for the audit team had been the 2025/26 Internal Control Evaluation (ICE). The final ICE report had been considered by Management and presented to Committee earlier in the meeting.

(ii) The Internal Audit Improvement Plan had been reviewed by the Partnership Board, which remained satisfied with progress. A further update would be presented to the Committee in March to evidence ongoing compliance with internal auditing standards.

(iii) The report also provided information on Audit Follow-Up, Completed Audit Work, and the Internal Audit Annual plan 2025/26.

The following points were made in discussion:

(i) Members sought clarification on how staffing constraints would influence delivery of the remaining audits. There had been a recent absence within the internal audit team, resulting in a need to re-prioritise the remaining elements of the 2025/26 audit plan. Discussions were underway with management to consider how best to phase the remaining audits, while maintaining sufficient audit coverage for the annual audit opinion. Any audits not completed by year-end would be risk-assessed and considered for inclusion in the 2026/27 audit plan. Any changes to the plan would be subject to Committee approval once the assessment was complete.

(ii) The Committee highlighted the importance of maintaining assurance coverage in areas where Board members had limited direct visibility, encouraging Internal Audit to preserve audits that provided insight into operational practice and frontline risk.

(iii) Members reflected on the balance between governance-focused and operationally-focused audits, noting that greater emphasis on practical, system-level assurance would support stronger oversight of organisational performance.

(iv) The Committee discussed the significance of the Adverse Events audit, stressing that assurance in this area remained a priority given its complexity and relevance to risk, quality, and public confidence. It was confirmed that the Adverse Events audit was well advanced with reporting to Clinical Governance Committee going forward.

The Audit & Risk Committee:

(1) noted progress with the delivery of the Internal Audit Plan and Internal Audit Activity.

(2) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and, where improvements were needed, clear actions had been identified.

7. Internal Audit Strategy 2025-2028

The Audit and Risk Committee considered a report for decision, presented by Jocelyn Lyall, which provided as an appendix the Internal Audit Strategy 2025 – 2028.

Key messages in the report included:

(i) The Internal Audit Strategy outlined the framework for enhancing the effectiveness of the Internal Audit service for the period 2025-2028. The Strategy covered the same period as the extant Internal Audit Strategic Plan.

(ii) The five Internal Audit Strategic Objectives were to:

- Enhance assurance coverage
- Manage talent and build audit capability
- Innovate and develop processes
- Position Internal Audit through Stakeholder engagement
- Report Internal Audit's performance & impact

Each Strategic Objective was supported by a suite of key strategic initiatives, mapped to the Internal Audit Improvement Action Plan.

The following points were made in discussion:

(i) Members sought clarification on whether the Strategy required Committee approval or was presented for assurance only. Internal Audit confirmed the Strategy had been approved by the Partnership Board and was presented for endorsement.

(ii) The Committee emphasised the need for Internal Audit to provide assurance in areas not otherwise visible to Board members. Internal Audit agreed and confirmed that this would be reflected in future planning.

(iii) Members queried the inclusion of detailed operational initiatives within what was intended to be a strategic document. Internal Audit noted these items were aligned to the wider Improvement Plan and included intentionally for strategic coherence.

(iv) Observations were made regarding the SWOT analysis, with members suggesting that opportunities should reference Internal Audit's role in enhancing insight into operational activity. Internal Audit agreed to consider this in future versions.

(v) Clarification was provided on the small internal audit budgets for Integration Joint Boards, with Members noting that most assurance was already derived from Health Board and Local Authority audits.

The Audit & Risk Committee:

(1) noted that the Internal Audit Strategy complied with GIAS requirements and supported the vision and key priorities of NHS Forth Valley.

(2) endorsed the Internal Audit Strategy 2025-2028.

(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and, where improvements were needed, clear actions had been identified.

8. Audit Follow Up Report – January 2026

The Audit and Risk Committee considered a report for assurance, presented by Anne Marie Machan, which provided a summary of the Audit Follow Up (AFU) position for the period to 31 December 2025.

Key messages in the report included:

(i) 21 audit actions were followed up during this cycle, seven being confirmed as fully complete. A further nine actions were assessed as likely complete, subject to receipt of minor outstanding evidence required for final validation.
(ii) Five actions remained extended beyond their original target dates. Only one raised material concern: Sustainable Transport Policy. The delay was primarily due to the passage of time rather than lack of progress.
(iii) Internal Audit had found no significant issues within the extended actions and overall implementation progress was satisfactory. Improvements continued to be observed in the timeliness and quality of audit action closure.
(iv) Assurance committees continued to oversee the audit actions relevant to their committees.

The following points were made in discussion:

(i) Since preparation of the report, Internal Audit had received additional evidence for three of the nine partially validated actions, enabling these to be concluded as fully complete, reducing the outstanding number accordingly.
(ii) Members queried the apparent discrepancy between the audit action tables and the narrative, noting difficulty reconciling the status of certain actions. It was clarified that some differences reflected timing, with updates received after the report had been issued.
(iii) Questions were raised regarding several significant actions marked amber, with Members seeking assurance on whether this level of outstanding risk was typical or concerning. The positions were not unusual and Internal Audit would highlight any actions presenting material concerns.
(iv) The Committee observed that although numerous actions had been closed, this did not appear to shift overall risk positions. Members noted that repeated closure of lower-level actions did not necessarily affect overall strategic risk.
(v) Members identified timing inconsistencies between different sections of the report, particularly around workforce-related actions, and Internal Audit confirmed these arose due to updates received after committee papers were finalised. A commitment was made to resolve this in future cycles.
(vi) Discussion took place on the identification of “emerging risks,” with Members commenting that the terminology could be misleading. Internal Audit agreed that the approach to identifying and reporting emerging risks could be strengthened through the ongoing development of risk management processes.

The Audit & Risk Committee:

(1) Noted the implementation status of management actions.
(2) Noted the Internal Audit assessment for extended action by dates.
(3) Agreed that overall progress and any residual risk was considered acceptable.
(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and, where improvements were needed, clear actions had been identified.

9. Counter Fraud Update Report – January 2026

The Audit and Risk Committee considered a report for assurance, presented by Anne Marie Machan, which provided an update on Counter Fraud Services (CFS) activity since October 2025 and outlined the current position of NHS Forth Valley’s local counter fraud activity.

Key messages in the report included:

(i) NHS Forth Valley participated in International Fraud Awareness Week, with the Counter Fraud Service expressing satisfaction regarding the Board's engagement.
(ii) The 2024/25 Counter Fraud Standards self-assessment had been submitted, and revised national fraud standards were under consultation, with expectations on Boards likely to increase due to the Economic Crime and Corporate Transparency Act.
(iii) Referrals to the Counter Fraud Service had decreased slightly in the most recent quarter, although early indications suggested rising levels, and NHS Forth Valley continued to maintain the highest fraud awareness training completion rate in Scotland.
(iv) Work was progressing on the organisational risk assessment required under the Economic Crime and Corporate Transparency Act, with national guidance expected to be strengthened through a forthcoming joint session hosted by the Counter Fraud Service and the Central Legal Office.
(v) Staff-related allegations continued to form the majority of referrals, and additional communication materials would be considered to reinforce expected conduct standards; an update on Operation Orville confirmed that the GMC process remained ongoing with no new developments.

The following points were made in discussion:

(i) The Committee acknowledged the link between the Economic Crime and Corporate Transparency Act and the forthcoming Counter Fraud standards, noting the importance of receiving clear national guidance to support Board compliance. Members welcomed confirmation of the upcoming joint Counter Fraud Service and Central Legal Office session.
(ii) Questions were raised regarding the broader organisational implications of the new legislation, including its potential impact on internal policies, training, whistleblowing, and supplier due diligence. Members sought assurance that these requirements would be reflected within future audit work once the risk assessment was complete. Although initial national guidance had been limited, further material was now emerging, including FAQs and the planned national session. The Board's risk assessment would incorporate this updated guidance once available.
(iii) It was recognised that many existing Board processes were likely to support compliance with the new legislation, although some gaps may be identified through the risk-assessment process. The Committee noted the importance of understanding any additional requirements placed on Boards arising from the Act.
(iv) In response to Member queries, Internal Audit confirmed that the Act would be considered an emerging risk for inclusion within future audit planning, and that the forthcoming organisational risk assessment would inform the extent of audit coverage required.

The Audit & Risk Committee:

(1) Noted the updates from Counter Fraud Services.
(2) Noted the NHS Forth Valley position related to Counter Fraud Services activity.
(3) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and, where improvements were needed, clear actions had been identified.

Actions

(i) Complete the organisational risk assessment required under the Economic Crime and Corporate Transparency Act and report the concluded assessment to the March Audit & Risk Committee. **Anne Marie Machan**

(ii) Consider issuing additional internal communications to reinforce expected standards of staff conduct in response to the continuing volume of staff-related allegations. **Anne Marie Machan/Scott Urquhart**

10. External Audit 2026/27

The Audit and Risk Committee considered a report for decision, presented by Rebbecca McConnachie, on the External Audit Planning 2026/27.

Key messages in the report included:

(i) The External Audit Plan for 2026/27 included early engagement, interim testing and a smooth handover to the new Engagement Lead.
(ii) Audit Scotland's updated fee guidance may influence the final audit fee, which would be confirmed following discussions with NHS Forth Valley.
(iii) Materiality had slightly increased, but the audit approach and risk assessment remained consistent, with key risks focused on management override and completeness of expenditure.
(iv) Enhanced quality processes now applied automatically due to NHS Forth Valley's >£1bn expenditure level, preventing last-minute process changes experienced in the previous year.
(v) The audit would continue to use advanced analytics and sector learning to strengthen assurance, and both Deloitte and NHS Forth Valley must maintain appropriate resourcing to deliver the agreed timetable.

The following points were made in discussion:

(i) Members welcomed the earlier timing of the audit plan and noted that learning from the previous year, particularly regarding the impact of Public Interest Entity (PIE) requirements, had now been built into the initial planning cycle, reducing the risk of timetable disruption.
(ii) Audit Scotland had recently set out a proposed 4.3% fee uplift across NHS audits, and discussions were ongoing nationally given the above-inflation nature of the increase.
(iii) A Committee member sought assurance that the issues experienced in the previous year's audit would not recur. There was confidence in the revised timetable, noting that success remained dependent on robust resourcing from both the audit team and NHS Forth Valley.
(iv) Members emphasised the importance of Deloitte applying sufficient staffing and expertise to the audit, stressing that the process must be treated as a partnership and that assurance on resource allocation was essential for maintaining audit quality.
(v) Further discussion focused on the benefits of sharing best practice and lessons learned from other NHS audits, with Deloitte confirming that sector learning, technical updates, and insights from other health boards would continue to be provided to strengthen readiness and improve audit effectiveness.

The Audit & Risk Committee:

(1) Approved the External Audit Plan for 2026/27.
(2) Noted that Audit Scotland's fee setting and the proposed uplift would be subject to further discussion.
(3) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and, where improvements were needed, clear actions had been identified.

11. Audit Scotland Reports: NHS in Scotland Report and Delayed DIscharges

The Audit and Risk Committee considered two recent Audit Scotland Reports for assurance presented by Scott Urquhart.

Key messages highlighted from the reports included:

(i) The NHS in Scotland report emphasised the publication of several key national policy documents—including the Operational Improvement Plan, the Service Renewal Framework, and the Population Health Framework—and highlighted that, while these documents provided clearer national direction, there remained a significant gap between national ambition and operational delivery capacity across NHS Boards.
(ii) The document included a detailed national overview of financial sustainability, drawing attention to continued pressure on NHS finances and increasing reliance on non-recurring support measures, which remained a core risk across NHS Scotland.
(iii) The report presented system-wide analysis on performance trends, acknowledging both service pressures and areas of improvement.
(iv) The report provided meaningful context for local planning and its findings would continue to inform NHS Forth Valley's internal discussions, particularly in relation to financial planning, operational performance, and longer-term system reform.
(v) In terms of delayed discharges a national overview was provided of the scale and impact of hospital discharge delays across Scotland.
(vi) There were increasing number of delayed discharges and associated costs which created substantial operational challenges for Boards.
(vii) The report included recommendations for strengthening national guidance and improving consistency across Health and Social Care Partnerships to address the systemic nature of the issue.

The following points were noted in discussion:

(i) Members noted that NHS Forth Valley's performance on delayed discharges had improved.
(ii) The Committee discussed the continued impact of Adults with Incapacity (AWI) cases, recognising that statutory processes, including guardianship, remained a major contributor to complex delays. The use of 13ZA provisions in Falkirk had supported improved flow for certain patient groups.
(iii) Members recognised that delayed discharges remained closely connected to findings from recent external inspections, highlighting the need for continued oversight.
(iv) The Committee welcomed confirmation of a business case being finalised to increase capacity to address backlogs and strengthen the management of complex delays.

The Audit & Risk Committee noted the contents of the Audit Scotland reports.

12. Strategic Risk Register Update (November 2025 - January 2026)

The Audit and Risk Committee considered a report for assurance, presented by Vicky Webb, which presented an update to the Strategic Risk Register for the period of November 2025 through to January 2026.

Key messages in the report included:

(i) All strategic risks had been reviewed during the reporting period, with the majority of scores remaining static; the only change was a reduction in the score for Strategic Risk 9 (Workforce Planning), which had been endorsed by the Staff Governance Committee.
(ii) 14 control actions had been completed during the period and no strategic risk actions were overdue, reflecting continued progress in strengthening the control environment.
(iii) The updated scoring resulted in 0% of risks sitting within the Board's stated risk appetite, with 33% now within tolerance levels and the remainder sitting above tolerance.

(iv) Four focused reviews had been undertaken in the period—Scheduled Care, Finance, Workforce, and Estates—and each had been endorsed as providing reasonable assurance.
(v) Ongoing activity by the Corporate Risk Management Team, included substantive work to review and refine the Board's Risk Management Framework and Risk Appetite methodology, with further developments to be brought forward in due course.

The following points were made in discussion:
(i) Members praised the strong report and noted the continued maturity and effectiveness of the organisation's risk management system.
(ii) The Committee highlighted limited movement in strategic risk scores, stressing that effective risk management should ultimately show reduced risk exposure or reframed risks. Static scores may suggest risks were too broadly defined or that controls lacked impact. Members agreed this should be explored further in the ongoing Risk Framework review.
(iii) An inconsistency around Strategic Risk 9 (Workforce Planning) was raised. It was confirmed that this reflected timing differences between the focused review and its later endorsement by the Staff Governance Committee.
(iv) Members noted that "actions completed" did not automatically reduce risk scores and emphasised the need for clear alignment between actions, assurance, and measurable risk reduction.
(v) A query on the statement "no emerging risk hotspots" prompted clarification that this referred only to outputs from the formal risk process; broader emerging risks (e.g., demographics, AI) would be considered through the wider framework review.
(vi) Members welcomed ongoing work to refine risk appetite and tolerance, recognising their importance for governance clarity and Board decision-making.

The Audit & Risk Committee:
(1) noted the changes to the Strategic Risk Register for this reporting period (Nov'25-Jan'26).
(2) noted the focused reviews conducted on the Strategic Risks for this period.
(3) noted the work progressed by the Corporate Risk Management Team.
(4) considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

13. Meeting Dates 2026

The Audit and Risk Committee considered a report for assurance, presented by Jack Frawley, which set out the Committee's meeting dates for 2026.

Key messages in the report included:
(i) The Committee would meet:
- 23 January 2026
- 27 March 2026
- 12 June (provisional)
- Tuesday 16 June 2026 (accounts)
- Friday 30 October 2026

(ii) There was an additional meeting proposed for Friday 12 June, subject to confirmation with the Executive Lead, Committee Chair and Auditors which would consider ordinary business separately to the meeting on 16 June which would be exclusively focused on the accounts

The Audit & Risk Committee:

(1) noted the dates of meetings for 2026, and

(2) confirmed that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(i) Proposals for June meeting arrangements to be confirmed and update provided to March meeting. **Scott Urquhart/Jack Frawley**

14. Schedule of Business

The Audit and Risk Committee received the Schedule of Business for information.

15. Any Other Competent Business

There was no other competent business.

16. Matters to raise at Board

The Committee noted that key issues from the meeting, including the status of clinical policies and the Significant Adverse Events Review improvement actions, would be highlighted through Clinical Governance Committee reporting rather than escalated separately from Audit & Risk.

Members reflected that adopting a practice of noting, after each agenda item, whether matters required escalation could support clearer governance and assist with future reporting.

17. Date and time of next meeting: Friday 27 March 2026 at 9am.

Item 7.2

Minute of the Clinical Governance Committee Meeting held on Tuesday 13 January 2026

For: Assurance

Minute of the Clinical Governance Committee Meeting held on Tuesday 13 January 2026 at 9.00am in the Boardroom, Carseview House.

Present:
Mrs Kirstin Cassells (Non-Executive Director)
Mr Gordon Johnston (Non-Executive Director)
Cllr Fiona Law (Non-Executive Director)
Mr Stephen McAllister (Non-Executive Director)
Mr John Stuart (Committee Chair)

Mrs Neena Mahal (Board Chair)

In Attendance:
Dr Karen Adamson (Deputy Medical Director)
Miss Jennifer Brisbane (Corporate Services Assistant) Minute
Ms Laura Byrne (Director of Pharmacy)
Mr Ashley Calvert (Head of Clinical Governance)
Mr Jack Frawley (Board Secretary)
Mr Ronan Ging (Chief Nurse of Acute)
Professor Karen Goudie (Executive Nurse Director)
Mr Jonathan Horwood (Infection Control Manager) Item 9
Mr Andrew Murray (Medical Director)
Mrs Wendy Nimmo (Interim Head of Efficiency, Improvement & Innovation)
Mr Allan Rennie (Board Vice Chair) Observing
Dr Jennifer Rodgers (Dental Public Health Consultant) Item 11
Mr David Watson (Corporate & Acute Director of Nursing)
Miss Vicky Webb (Corporate Risk Manager)

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1. Welcome, Apologies for Absence and Confirmation of Quorum
There was an apology from Professor Clare McKenzie. The meeting was quorate.

2. Declarations of Interest
There were no declarations of interest.

3. Minute of Clinical Governance Committee held on 11 November 2025
The minute of the meeting held on 11 November 2025 was **confirmed** as an accurate record, subject to the amendment of Action 104, outlined in item 15a, noting that the Significant Adverse Event Review business case would not be presented back to the Committee after consideration from the Senior Leadership Team.

4. Matters Arising from the Minute/ Action Log
The Clinical Governance Committee reviewed the action log and noted the complete actions, and below updates:

- Actions 75 & 76: Committee members were advised that the Public Protection Report and detail on governance arrangements would be provided at the 17 March 2026 meeting due to work ongoing to complete the report. Action timescale **extended**.

- Action 85: The Clinical Governance Working Group's (CGWG) remit was confirmed, holding responsibility to ratify policies. Assurance was provided that oversight approval would be incorporated into CGWG Updates to the committee, action **complete**.
- Action 96: Confirmation was provided that the Professional Assurance Framework would be captured within the workforce governance route and therefore would be scheduled at the Staff Governance Committee, action **complete**.
- Action 104: A business case seeking additional resource to support Significant Adverse Event Review business case was presented to the Executive Leadership Team for consideration where further detail was sought. Assurance was provided that oversight would be undertaken by the Executive/ Senior Leadership Team, action **complete**.
- Actions 99, 100, 102, & 103 were noted as **complete**.

The Clinical Governance Committee noted the Action Log

Items 5a & 5b were taken in conjunction.

5.

(a) Clinical Governance Committee Planner

(b) Draft Committee Planner with Proposed Changes

The Clinical Governance Committee received the Committee Planner and Draft Committee Planner with Proposed Changes presented by Mr Andrew Murray, where an overview of proposed changes and rationale was provided.

Key messages in the paper included:

(i) An initial evaluation of the planner was undertaken following previous discussions regarding reporting of whole system information, determining whether agenda capacity could be reallocated to include individual directorate assurance reports, therefore supporting more detailed and specialised assurance. An initial paper was reviewed by the Committee on 11 November 2025, however the item was scheduled for further opportunity to comment on the proposals prior to the 2026/27 Forward Planner being finalised.

(ii) Committee members were reminded of the proposed changes, where it was noted that Cancer and Prison updates would continue to be presented to the Committee for assurance due to the high-risk nature associated with the services.

The following points were made in discussion:

(i) A committee member noted caution on the clarity required to evidence the governance of reports and Programme Boards from the CGWG to the Committee, seeking evaluation of compliance with milestones and key performance indicators.

(ii) Following discussion, the importance of Health & Social Care Partnership representation was noted.

(iii) A query was raised on the governance of the Research & Development where it was advised that related reports would be aligned to the Quality Programme Board.

(iv) Committee members endorsed the proposed changes, where reassurance was provided that a draft planner would be presented at the 17 March 2026 meeting for approval.

The Clinical Governance Committee:

(1) Noted the Committee Planner.

(2) Reviewed the proposed Committee Planner changes.

(3) Approved all changes to the planner set out in the report.

(4) Agreed the production of the 2026/27 Forward Planner.

6. For Approval

There were no items for approval.

7. In Our Services, Is Care Safe Today?

(a) Emerging Clinical Issues

The Clinical Governance Committee received the 'Emerging Clinical Issues' paper presented by Mr Andrew Murray, which provided an overview of an unannounced Healthcare Improvement Scotland (HIS) visit to Forth Valley Royal Hospital's (FVRH) Mental Health and Women & Children's Maternity services on 25 and 26 of August 2025.

Key messages in the report included:

(i) The Mental Health Inspection Draft Report was received, and the report response and completion of a factual accuracy check was required by 14 January 2026, with the Improvement Action Plan to be returned by Wednesday 21 January 2026.

(ii) The Maternity Services action plan was submitted to HIS, and it was advised that it would be circulated to committee members when available.

The following points were made in discussion:

(i) Assurance was provided that oversight groups were established for both workstreams to gather information and gain clarity on the requirements arising from the inspections.

(ii) Assurance was provided to the Committee that the Maternity action plan would be submitted in line with timescales, and the Committee was advised that oversight and monitoring of progress against the action plan will sit with the CGWG.

(iii) Concern was raised over the lack of oversight of the Maternity Services Action Plan at Committee prior to presentation at the 27 January 2026 Forth Valley NHS Board. It was agreed that consideration of a briefing to committee members prior to the Board would be undertaken to ensure assurance from the Committee to the Board.

(iv) The Chair sought assurance that the Forth Valley Royal Hospital bathroom review had been undertaken as referenced within the Item 20c Infection Control Committee Minute from October 2025. Reassurance was provided that all bathrooms onsite were assessed and given a RAG status, advising that the bathroom prompting concerns had been refurbished was open and fit for purpose.

(v) In preparation for future Healthcare Improvement Scotland Inspections, standard operating procedures were being developed and would be considered at the CGWG and Committee.

The Clinical Governance Committee:

(1) Noted the content of the report.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(1) Provide detail on the Maternity action plan and assurance on monitoring of progress at the CGWG. Karen Goudie/ Andrew Murray

(2) Circulate the Maternity Inspection outputs to the Committee prior to presentation to the Forth Valley NHS Board.

8. In Our Services, Was Care Safe in the Past?

(a) Acute Directorate Safety & Assurance Report

The Clinical Governance Committee received the 'Acute Directorate Safety & Assurance Report' presented by Dr Karen Adamson, providing assurance of robust clinical governance within the Acute Services Department (ASD), and appropriate scrutiny at the Clinical Governance Working Group (CGWG) for the Committee.

Key messages in the report included:

(i) Hospital Standardised Mortality Rate (HSMR) remained below the threshold of 1 at 0.92.

(ii) Adult Cardiac Arrest rate was 0.91 and 1.27 per 1,000 discharges for October and November, with a reduction in 45% of CPR (Cardiopulmonary Resuscitation) attempts for patients with valid Do Not Attempt CPR (DNACPR) decisions. Improvement work continued to address the 32% of cases that lacked appropriate DNACPR decisions.

(iii) Overall Stroke Bundle Initial Diagnosis compliance had remained unchanged at 55.3% in August 2025, with Final Diagnosis compliance reported at 58.8% in November 2025 from 48.6 % in October 2025, notably below the 80% target. Assurance was provided that NHS Forth Valley's rate was not out with the national position of 58% in October 2025. In-hours Door-to-Needle times for thrombolysis were strong however the out of hours performance remained limited due to reliance on other boards. Delayed admissions to the stroke ward and imaging delays persisted however swallow screening rates had improved.

(iv) Pressure Damage for the Acute Directorate within FVRH for November was 2.08 per 1000 occupied bed days for all grades (2.21 in October) and 1.14 per 1000 occupied bed days for hospital acquired pressure injury in November from 1.10 in October.

(v) Falls with Harm rate within the Acute Directorate was at 0.55 per 1000 occupied bed days in November 2025, which saw an increase from 0.26 in October 2025. All inpatient falls rate was at 13.8 per 1000 occupied beds days in November 2025.

(vi) Delays in the rollout of the Electronic Observation System (eObs) was experienced due to Wi-Fi connectivity issues impacting deteriorating patient workstreams due to transferal of data from monitors to TrakCare. However, a revised redesign plan was being developed and presented to the Programme Board to account for delays.

(vii) Mixed performance was noted within the Scottish Hip Fracture Audit, with strengths noted with Emergency Department to ward transfer, and time to surgery. However, NHS Forth Valley sat below the national average with inpatient bundle, nutrition care and early mobilisation.

The following points were made in discussion:

(i) Clarity was provided on the delays experienced with eObs where an approximate 3-month delay was noted.

(ii) A committee member sought continued scrutiny of the stroke bundle compliance., where reassurance was provided on the quality improvement approach adopted to ensure meaningful outcomes for teams.

(iii) Concern was raised in the increased rate of falls, where assurance was provided that 35% compliance was met against the 30% overarching aim of the Safer Together Collaborative and increases were likely as a result of improved safer mobility.

(iv) Confirmation was provided that increased recording of pressure ulcers at the front door was as a result of improved assessment and reporting.

The Clinical Governance Committee:

(1) Noted the position, challenges, and quality improvements being made in relation to the specific SPSP measures and compliance with national targets.

(2) Considered that the reported provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Whole System Assurance Report

The Clinical Governance Committee received the 'Whole System Assurance Report' presented by Mr Ashley Calvert, providing assurance that the clinical governance processes within each directorate were working as intended.

Key messages in the report included:

(i) Committee members were advised that it was the final time the report would be presented in the current format following discussion on the changes to the Committee Planner and the introduction of individual directorate level reports and representatives. Aiming to achieve sufficient assurance from directorates escalating key harms to the committee and evidencing areas of good practice and improvement. Reassurance was provided that a Corporate Clinical Governance Manager would be attending all governance meetings to provide directorates with support and maintain consistency in reporting to the Committee.

The following points were made in discussion:

(i) Committee members endorsed the proposal, emphasising the importance of focussing on key governance areas across all reports to ensure consistency and provide ease of reporting for teams. It was suggested that a rolling programme would be a good approach within the initial stages to support directorates and teams with reporting.
(ii) Emphasis was noted that reporting from the Health & Social Partnerships (HSCPs) was required at the committee due to the Clinical Care Governance reporting undertaken at the Integration Joint Board providing scrutiny from a commissioning lens.
(iii) Consideration of the representation at the committee was sought, where assurance was provided that the new Director of Community Nursing would join the committee providing representation for both HSCPs.
(iv) Clarity was sought on the escalation route of service issues to the committee where it was noted that issues would be raised to the CGWG where there was wider representation of the whole system.

The Clinical Governance Committee:

(1) Noted the agenda items discussed and presented at the Directorate Clinical Governance meetings, and data sources.
(2) Noted the data sources.
(3) Considered that the reported provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

9. Healthcare Associated Infection (HAI) Report

The Clinical Governance Committee received the 'Healthcare Associated Infection (HAI) Report December 2025' presented by Mr Jonathan Horwood. Which provided an oversight of the HAI targets, Staph aureus bacteraemias (SABs), Clostridioides difficile infections (CDIs), Device associated bacteraemias (DABs), Escherichia coli bacteraemias (ECBs) incidents, outbreaks and all other HAI activities across NHS Forth Valley.

Key messages in the report included:

(i) Total SABs, DABs, CDIs and ECBs reported cases remained within controlled limits.
(ii) Within the reporting period of December 2025, there were:
- 2 hospital acquired SABs.
- 3 hospital acquired DABs.
- 2 hospital acquired CDIs.
- 3 hospital acquired ECBs.
- 4 surgical site infections reported from post C-sections as a result of extended surveillance initiated locally, of which all cases were at home, beyond 10 days post-surgery and were of a high Body Mass Index commonly associated with increased surgical site infections. Reassurance was provided that discussion would be undertaken with the Women & Children's directorate to address concerns.
- 1 outbreak reported (Norovirus)

(iii) A reduction in hand hygiene compliance was noted, and assurance was provided that monitoring would be prompted through scheduled discussions at local governance committees.
(iv) An increase in Standard Infection Control Precautions assessed through the Ward Visit Programme was noted with assurance provided that non-compliance was highlighted to the nurse in charge at time of audit and any equipment identified with cleanliness issues was rectified immediately.
(v) Influenza rates increased earlier than previous years as anticipated, peaking at the beginning of December with 45 inpatients. Following the peak a steady decline over the proceeding week with a daily average od 10 inpatients was recorded.

The following points were made in discussion:
(i) Concern was raised over the specific 'Bare Below Elbow' non-compliances identified at ward visits, where it was agreed that rolling communications to campaign such requirements was required.

The Clinical Governance Committee:
(1) Noted the report.
(2) Noted the performance in respect for SABs, DABs, ECBs & CDIs.
(3) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

10. Scottish Patient Safety Programme (SPSP) Delirium
Item deferred to align with the Clinical Governance Working Group reporting.

In Our Services, Will Care Be Safe In the Future?

11. Public Health Update
The Clinical Governance Committee received the 'Public Health Update' paper presented by Dr Jennifer Rodgers, where an overview of the governance arrangements and structure of the Sexual Health/ Blood Bourne (SHBBV) Managed Clinical Network (MCN).

Key messages in the report included:
(i) The governance arrangements and structure of the Sexual Health/ Blood Bourne Virus (SHBBV) Managed Clinical Network (MCN) was being considered within the Public Health Directorate.
(ii) A full scoping exercise was completed and a proposed new structure incorporating Sexual Health, Hepatology and wider MNC functions had been agreed in principle by the Director of Public Health.
(iii) During a Scottish Government visit in December 2025, the intended alignment of the redesign with the Population Health and Care Strategy and shift towards prevention. Reassurance was provided that the report from Scottish Government would be included in the next update to the Committee.

The following points were made in discussion:
(i) Following discussion on future reporting, further structure and measurement methods such as RAG statuses were sought to evaluate ongoing progress and gain assurance.

The Clinical Governance Committee:
(1) Noted the contents of the report.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

12. Risk Management

(a) Strategic Risk Register

The Clinical Governance Committee received the 'Strategic Risk Register' paper presented by Miss Vicky Webb, which provided an update on the Strategic Risk Register, with a focus on the risks aligned to the Committee.

Key messages in the report included:

(i) The below strategic risks aligned to the committee were reviewed, where it was noted that there were no changes to the risk profiles:
- SRR002: Urgent & Unscheduled Care
- SRR004: Schedule Care

(ii) There were 20 controls mitigating the strategic risks aligned to the Committee with no overdue actions and 7 actions due to be completed within the next quarter.

(iii) At the end of quarter 3, the Forth Valley NHS Board's Strategic Appetite and Tolerance remained static.

The following points were made in discussion:

(i) Reassurance was sought on a further control required on within section 2.1.2 on SRR002 Urgent & Unscheduled Care, referencing a visit regarding the development of a Front Door Protocol and the actions timescale of 31 January 2026. Assurance was provided that work from the action would be incorporated into the 12-Week Urgent & Unscheduled Care Rapid Action Plan and the timescale of the action would be reviewed after the 27 January 2026 Board meeting.

(ii) Following discussion on the new sub-national planning structures and approach to addressing long waits through mutual aid, consideration was sought on incorporating potential risks aligned and amending the risk description of SRR004: Scheduled Care to reflect sub-national plans.

The Clinical Governance Committee:

(1) Endorsed the Clinical Governance Strategic Risks for the period December 2025 to January 2026 for onward reporting the Forth Valley NHS Board.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

The Committee adjourned at 10:55am and reconvened at 11:05am with all members present as per the attendance list.

Item 14 was taken at this point in the agenda.

14. Organ & Tissue Donation Annual Report

The Clinical Governance Committee received the 'Organ & Tissue Donation Annual Report' presented by Dr Abigail Short, which provided an overview of the Forth Valley Royal Hospital Organ & Tissue Donation Committee for 2025/26 Annual Report.

Key messages in the report included:

(i) From April to September 2025, data evidenced that NHS Forth Valley met the NHSBT standards with no missed donation opportunities and 100% of families approached proceeded with donation. As a Level 3 Board, donation targets had exceeded the target of 3 to 6 proceeding donors per year, evidencing an increased awareness.

(ii) Educational outreach work was undertaken with the University of Stirling, raising community awareness through campaigning at the University. Work was ongoing with Quality Improvement to facilitate simulation training with resident doctors. Memorial benches were being considered to commemorate donors and involve community groups in the development.

(iii) Challenges were noted with tissue donation, specifically eye and bone donation, therefore work was ongoing with local hospices and the palliative care team to raise awareness. A new bone donation programme had successfully commenced, where donations were obtained through elective hip replacements.

The following points were made in discussion:
(i) Committee members commended Dr Abigail Short and the Organ & Tissue Donation Committee for its improvement work and increased visibility of such donations.

The Clinical Governance Committee:
(1) Noted the annual report.
(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Is Our Care Person Centred?

13. Person Centred Care Report

The Clinical Governance Committee received the 'Person Centred Care Report' presented by Dr David Watson providing comprehensive review of complaints activity across NHS Forth Valley including the number of complaints received, local resolution, compliance with the 20-day national target, Scottish Public Services Ombudsman (SPSO) referrals and examples of actions taken following complaints.

Key messages in the report included:
(i) At the time of reporting there were:
- 185 open complaints, which saw a reduction of over 50% since August 2025. Of which, there were 17 at Stage 1, with the remaining in Stage 2 and 41 awaiting approval.
- Stage 1 performance was at 86%, whilst Stage 2 was at 38% seeing an 18% improvement, however the requirement for further improvements were identified.

(ii) Wider shared learning from complaints was required and would be facilitated by the planned transition of data to the Safeguard system, enhancing thematic analysis and action planning.
(iii) There were 20 active SPSO complaints within 1 being fully upheld. Assurance was provided that feedback from the SPSO recognised improved openness and quality of responsiveness.
(iv) 87% of Care Opinion feedback was non-critical, with only 3% identified as critical and the remaining as moderate. It was noted the utilisation and visibility of Care Opinion would be a focus for 2026.

The following points were made in discussion:
(i) Committee members were advised that detail on the upheld SPSO complaint was outlined within Item 21a.
(ii) Following discussion, committee members emphasised the need to further promote Care Opinion, where it was suggested that the work undertaken to develop a dashboard could be presented to the Forth Valley NHS Board.
(iii) A query was raised on potential areas of opportunity to mitigate complaints through early intervention and access to information providing patients with detail on systems and procedures. Assurance was provided that such work would be undertaken through the Model Complaints Recording Process and thematic analysis from Safeguard.
(iv) A committee member sought trajectories aligned with backlog timescales to evidence progress, where assurance was provided that weekly monitoring of complaints was undertaken by the Senior Leadership Team.

The Clinical Governance Committee:

(1) Noted the organisational risk attached to the current position.
(2) Noted the challenges in demand and capacity within the service and steps taken to improve performance within budget.
(3) Noted the action and mitigation plans.
(4) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:
(1) Incorporate trajectories against backlog timelines to evidence progress. David Watson/ Karen Goudie

15. Are We Learning and Improving?
(a) Significant Adverse Event Report

The Clinical Governance Committee received the 'Significant Adverse Event Report' presented by Mr Ashley Calvert, which identified a high operational risk, and a supporting mitigation programme and improvement plan.

Key messages in the report included:
(i) An overview of the ongoing improvement to enhance adverse event reporting was provided, noting the improved links between Significant Adverse Events (SAE) and complaints.
(ii) National work was undertaken to standardise what constitutes as a Category 1 adverse event due to variation across health boards. Reassurance was provided that processes were aligned with national standards, with early escalation simplified through the shift to an electronic system, anticipated by the end of February 2026.
(iii) The average time taken to commission a SAER was 42 days, exceeding the target of 10 working days. Challenge was noted with panel formation, specifically those that required external reviewers, however reassurance was provided that process changes had resulted in improvements and confidence was noted in achieving the 90% target by the end of 2026.
(iv) At time of presenting there were 34 open SAERs, of which:
- 1 was submitted for final report approval.
- 4 were at draft report stage.
- 13 were at team meeting stage.
- 16 were at panel formation stage.

(v) In 2025 28 SAERs where commissioned, with 24 previously commissioned SAER being closed within the calendar year.

The following points were made in discussion:
(i) Following discussion, committee members emphasised the importance of maintaining quality reviews however noted the need to ensure sufficient resource was available to the team to meet targets.
(ii) Clarity was sought on the SAER 134 which was commissioned in 2024 however remained in the team meeting stage, where it was advised that such delays were due to the complexity of the case as a Stage 2 complaint requiring external panel membership.
(iii) A committee member suggested proposing a pool of lead reviewers to Healthcare Improvement Scotland to support prompter panel formation nationally.
(iv) A question was raised regarding the necessity for Women & Children SAERs to include an external reviewer, with clarification provided that this is a requirement mandated by the Scottish Government.
(v) Additional information about recurring themes in learning summaries, along with confirmation that lessons learned were communicated, was requested in future updates.

The Clinical Governance Committee:

(1) Noted NHS Forth Valley's position.

(2) Noted the proposed creation of a business case for additional resource to be taken to the Senior Leadership Team in January 2026.

(3) Considered that the report provided limited assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

Action:

(1) Provide further detail on themes of learning summaries and provide further assurance that lessons learned are communicated. Ashley Calvert

(b) Safer Together Collaborative Update

The Clinical Governance Committee received the 'Safer Together Collaborative Update' paper presented by Dr David Watson, providing an update on the progress of the Safer Together Collaborative (STC), highlighting measurable improvements across all workstreams, increased by Quality Improvement capability, and plans for transition into a new governance framework. In addition to providing highlights from the Safer Together Celebration Event held on 13 November 2025.

Key messages in the report included:

(i) A Safer Together Collaborative event was held in November to provide an opportunity to celebrate successes of the improvements achieved through the collaborative approach adopted.

(ii) The below key improvements were noted:

- A 35% total reduction in falls and falls with harm was achieved, exceeding the overarching aim of 30%.
- Pressure Ulcer rates had reduced from 3.23 in October 2024 to 0.95 per 1,000 occupied bed days at the end of the collaborative.
- A reduction in cardiac arrest rates was noted with a shift from the 90 centile to the 25 -75 centile, with a reduction from 1.83 in August 2024 to 0.86 per 1,000 discharges in November 2025.

(iii) Despite the completion of the collaborative, reassurance was provided that ongoing measurement and monitoring would be undertaken by the Safety Steering Group.

The following points were made in discussion:

(i) Committee members commended colleagues for the work undertaken and improvements gained through the collaborative.

(ii) A query was raised on the challenged experienced with Treatment Escalation Plan (TEP) implementation and if staff were provided with protected time where it was noted that here was no protected time however several tests of change were being undertaken to widen TEPs to a business-as-usual arrangement.

(iii) Following a question raised on opportunities for project sharing, it was noted that the monthly Quality Improvement Academy and Annual Quality Celebration Event offered staff that space. Committee members were advised of the Quality Management System work that focused on creating a learning organisation and were assured that an update on progress would be provided at a future meeting.

The Clinical Governance Committee:

(1) Noted the improvements against high-level improvement aims and measurable outcomes.

(2) Noted the progress with development of the infrastructure and systems to support the quality planning and assurance.

(3) Noted the transition plans after November 2025, including governance alignment and sustainability strategy.

(4) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

16. Are Our Systems Reliable?

(a) Internal Audit Follow Up Actions

The Clinical Governance Committee received the 'Internal Audit Report 'presented by Mr Ashley Calvert, which provided oversight of the audit actions aligned to the remit of the Clinical Governance Committee.

Key messages in the report included:

(i) Of the actions aligned to the Committee:

(ii) A10/26 Action Points 9 and 10 were noted as outstanding with timescales of 31 March 2026 and 31 December 2025. Assurance was provided that both actions were anticipated to be completed within the timescale.

(iii) There were 4 open actions following the Internal Audit Report A15/25 Adverse Event Management:

- Audit Finding 2: Improvement Plan Milestones. Assurance was provided that the action of commissioning of SAERs within 10 working days was anticipated to be completed by mid-2026 following the ongoing improvement work previously discussed.
- Audit Finding 3: Sharing of Learning from Adverse Events.
- Audit Finding 5: Local Management Team Reviews Progress Monitoring.
- Audit 6: Improvement Monitoring.

(iv) A draft Internal Control Evaluation Report with recommendations would be reviewed by the committee at a future meeting. The Acting Director of Strategic Planning & Performance was reviewing the narrative of the report to extract further recommendations and aligns those with respective Assurance Committees.

The Clinical Governance Committee:

(1) Noted that the management response to findings would be reviewed by the committee through the Internal Audit Follow Up Actions Report.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

(b) Clinical Governance Working Group Update

The Clinical Governance Committee received the 'Clinical Governance Working Group Update' presented by Mr Ashley Calvert, which provided an update from the Clinical Governance Working Group in relation to key items discussed, noted and approved.

Key messages in the report included:

(i) The items considered at the CGWG were:

- Food, Fluid & Nutrition (FFN) Policy
- Healthcare Improvement Scotland– Safe Delivery of Care
- Whole System Assurance Report
- Healthcare Associated Infection Report
- Risk Management Update
- Clinical Policies & Guidelines
- Person Centred Care Report
- Significant Adverse Event Review Report & Resource for Clinical Governance Department

- Internal Audit- Adverse Event Management
- Healthcare Improvement Scotland Evaluation Form

The following points were made in discussion:

(i) A committee member noted the positive feedback on patient food provided by members of the public on social media platforms, where it was suggested that Board members could try hospital catering to gain an insight into inpatient experiences.

The Clinical Governance Committee:

(1) Noted the paper and key issues that arose from the Clinical Governance Working Group.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

17. Clinical Policies and Guidelines

The Clinical Governance Committee received the 'Clinical Policies and Guidelines Report' presented by Ms Laura Byrne, which provided a summary of the progress made with the Organisational Risk ORG 21: Clinical Policies and Guidelines.

Key messages in the report included:

(i) Progress was noted in addressing overdue clinical guidelines and policies, where bow-tie analysis was undertaken to recognise documents were not required as a clinical guideline. A risk-based RAG tool was tested within the Mental Health & Learning Disabilities directorate which resulted in 37% of guidelines identified as standard operating procedures and would be used across all clinical service units for classification of policies and future monitoring purposes.

(ii) A comprehensive programme of work was actively progressing, with complete of housekeeping and RAG status expected by the of end of January 2026. Further discussions were ongoing in relation to the development of Key Performance Indicators and target timescales for assurance purposes.

The following points were made in discussion:

(i) Assurance was provided that departments were sought to consider the use of national guidelines to reduce development of local unnecessary guidelines.

(ii) Following discussion on the national procurement of the Right Decision Service (RDS), assurance was provided that concerns regarding the website not deemed as value for money was raised at a national level, and internal development would continue due to the success achieved to date.

The Clinical Governance Committee:

(1) Agreed that 6 monthly reporting was acceptable to demonstrate progress and assurance to the Committee.

(2) Considered that the report provided assurance that appropriate controls were in place to manage the identified risks, support the delivery of objectives and where improvements were needed, clear actions had been identified.

18. Public Protection Annual Report

Item deferred to align with the Clinical Governance Working Group reporting.

19. For Noting

The Clinical Governance Committee noted the Organ & Tissue Donation Activity Letter.

20. The Clinical Governance Committee noted the minutes from the below associated Clinical Governance Groups:

(a) Clinical Governance Working Group Minute 09.10.25

(b) Organ & Tissue Donation Committee Minute 04.06.25

(b) NHS Forth Valley Infection Control Committee Minute 29.10.25

21. The Clinical Governance Committee noted the below Standards and Reviews Reports:

(a) September 2025

(b) October 2025

22. The Clinical Governance Committee noted the below Scottish Patient National Audit Programmes:

(a) Scottish Hip Fracture Audit

(b) Scottish Trauma Audit Group

23. Any Other Competent Business

Committee members were asked to note the Value Based Health & Care Launch taking place 22 January 2026 at 9:30am in the Lecture Theatre at Forth Valley Royal Hospital and were encouraged to attend.

24. Matters to Raise at Board

The Chair highlighted that key matters discussed would be raised at the 27 January 2026 Forth Valley NHS Board meeting.

25. Date and Time of Next Meeting

Tuesday 17 March 2026 at 9:00am, in the Boardroom, Carseview House.
The Chair closed the meeting at 12:55pm.

7.3 **Ratified** Minute of the Area Partnership Forum meeting held on Tuesday 16 December 2025 at 2 pm, via MS Teams.

Present: Robert Clark, Employee Director (Chair)
Ross McGuffie, Chief Executive, (APF Joint Chair)
Elaine Macdonald, Interim Head of HR
Emma Small, RCN
Garry Fraser, Acute Services Director
Janet Sneddon, RCM
Karen Goudie, Executive Nurse Director
Karen Leonard
Karren Morrison, Unison
Kevin Reith, Director of People
Laura Bryne, Director of Pharmacy
Linda Robertson, HR Manager Staff Governance
Lynsey Walker, British Dietetics Association
Michael Brown, Head of Workforce and Resourcing
Morag Farquhar, Director of Facilities
Nicholas Hill, GMB
Stephen Feltblower, BMA
Tom Cowan, Head of Strategic Planning & Transformation for Falkirk HSCP/Head of Primary Care for Forth Valley

In Attendance: Sarah Smith (Note)

Before the meeting commenced, Ross McGuffie advised the APF that the meeting had previously been stood down to create space and reduce non-essential meetings due to site pressures. However, colleagues had highlighted the need for discussion during the challenging period.

1. Apologies for Absence/Confirmation of Quorum

Apologies for absence were noted on behalf of: Carole Murray, Julie Mitchell, Kevin Bye, Pamela Bowman, Linda McGovern, Jenny McCusker, Scott Urquhart.

2. Declaration(s) of Interest(s)

There were no declarations of interest made.

3. Draft minute of meeting held on 28 October 2025

The note of the meeting held on 28 October 2025 was approved as an accurate record.

4. Action Log

The action log was reviewed and would be updated to reflect discussions.

63 Partnership Working on Intranet – Progress was ongoing with assistance being provided by a Modern Apprentice. Aim was to share a link early in 2026 with action to be closed at the next meeting.
73 Absence management Review Group – Action would be carried forward to the next meeting.
80 Car Leasing – Action would be carried forward to the next meeting.
85 Excessive temperatures – Morag confirmed a variation was being agreed with Forth health and Serco with baseline data being gathered. Expectation was for further update in the new year.

91 RWW – On Agenda. COMPLETE
93 Anti Racism Plan – Plan will be taken to January Board for approval. COMPLETE
94 AOCB Vandalism to staff cars @ FCH – Additional camera was being added to ensure full coverage of the car park. Timeframe was to be confirmed.
95 AOCB Workforce Policies Phase 3 – Further update to be brought to the next meeting.

5. Matters arising from the minute/action log

There were no matters arising.

6. Site Pressures

The APF were provided with an overview of the position by Ross McGuffie.

Colleagues were advised of the sustained pressures on the site since August, with a significant spike in activity and flu presentations in early December. This had led to the decision to stand down all non-essential meetings and redeploy senior staff to the site for direct ward engagement. The implementation of the "criteria to reside" process was discussed, with evaluations from the first two weeks indicating improvements in patient flow, reduced length of stay, increased discharges, fewer contingency beds, and a reduction in boarders.

Systemic challenges were identified, particularly regarding the community waiting list, which included approximately 50 patients and highlighted issues with four separate discharge teams operating on different data sets. The need for a unified approach and single data source was emphasized to improve discharge planning and patient outcomes. The work aligned with the "discharge without delay" model, focusing on integrated discharge arrangements. Further discussions were held on formalising the ‘criteria to reside’ approach and embedding into ongoing practice.

Garry Fraser provided operational context, describing the acute pressures experienced, including long ambulance waits and limited bed availability. He commended staff efforts and noted that collaborative working across health, social care, and acute teams had mitigated risks and improved system resilience. The closure of contingency beds was highlighted as a positive outcome, with 15–20 beds closed recently and plans to sustain this progress over the next six weeks. Caution however was requested, noting data from Australia had noted a decrease followed by a further surge in cases.

Clarity was sought around the position of A11, with Garry confirming recent extensive refurbishment, which included rewiring, bathroom refits, and redecorating. The only outstanding work was flooring, which was not an urgent issue. As set out previously, ward A11 will now be used as a contingency ward, supporting expanded capacity during periods of surge and supporting the decant of other wards to support ongoing refurbishment programmes. It is planned to use A11 for surge in January and early February when patient numbers traditionally rise. Staffing plans were being developed to ensure the ward could be activated and operated effectively whenever required. From February onwards, the ward will be used for decant to support the ongoing refurbishment work across the site around bathrooms and rewiring.

Staffing mitigation for extra beds was addressed, with ongoing challenges in Healthcare Support Worker availability due to high sickness absence and difficulties in filling shifts. Concerns were raised by Nick and Karren regarding staff well-being, staffing levels, and the impact of contingency beds on workforce safety and morale. The need for improved recruitment, bank shift management, and monitoring of staff breaks was discussed, with calls for enhanced support and escalation processes.

Karen Goudie reported on workforce governance, noting an over-recruitment of registered nurses to provide additionality of support. However significant sickness absence was recognised among HCSW. Recruitment efforts and blueprint reviews were ongoing to address staffing needs and contingency bed requirements. The importance of monitoring staff breaks and well-being was reiterated, with escalation routes through lead nurses and operational managers to address any issues.

Clarity was sought around mitigation measures that were put in place for staffing when additional beds were opened. Reassurance was provided by Garry Fraser that for medical staffing, a boarding team was set up, mainly using locums. For nursing and healthcare support workers, efforts were made to staff the extra beds safely, but there were significant challenges due to high sickness absence, especially (as discussed previously) among healthcare support workers. Attempts were made to fill shifts, but there was limited uptake, and this was a major pressure point over the weekend.

Stephen raised questions around escalation protocols during times of stress on the site and major incident criteria, with Garry Fraser and Ross McGuffie providing clarity around the use of the OPEL score for system-wide escalation and the limitations of declaring a major incident when neighbouring boards were similarly constrained. In early December, the purple OPEL score resulted in senior staff clearing diaries and supporting a major criteria to reside response to improve flow, which has continued for over two weeks, providing an example of the escalation protocol in action.

The need for proactive planning for predictable periods of high demand, such as January, was emphasised, with a focus on changing risk appetite and balancing system pressures. Communication of escalation and response plans was discussed, with agreement around the need to ensure clearer messaging around the actions being taken to all staff and also public messaging to reduce attendances during periods of significant site pressure.

Action: Garry Fraser/Ross McGuffie

7. Reduced Working Week

The APF received an update on the reduced working week, led by Kevin Reith and Elaine Macdonald.

A comprehensive update was provided around the reduced working week, highlighting that phase two of the project was progressing well. The oversight group, which had previously met monthly, would return to a fortnightly schedule after the new year to ensure closer monitoring.

Financial planning was a key focus, with efforts underway to identify which service areas would require additional resources and which could absorb the reduction in working hours through new ways of working. However, concerns were raised around the funding allocated to the Board being insufficient to cover all service needs, which could result in some services having to absorb reductions without additional support. Risks identified include the possibility of insufficient staffing hours, challenges in maintaining compliance with safe staffing legislation and potential recruitment difficulties.

Particular challenge was noted around staff who currently worked three shifts of 11.5 hours each. Full application of the reduced working week would result in a 1.5-hour shortfall each week, raising concerns that staff may be required to come in for very short shifts, which could negatively affect work-life balance and potentially increase staff absence. A proposal was made to allow these shortfalls to be accumulated over a four-week roster period, enabling staff to take a longer shift once per roster instead of multiple short shifts. The approach aimed to minimise disruption and support staff well-being.

Staff side raised concerns about the lack of clear governance and communication around the implementation of the reduced working week. Some managers were reportedly unsure of the correct process, leading to inconsistencies. There was consensus that a clear mechanism and guidance were needed, with local partnership forums responsible for approving exceptions and reporting to the Area Partnership Forum. It was agreed that joint communications and a report to the APF would be developed as next steps to ensure transparency and consistency.

Action: Kevin Reith/Elaine Macdonald

Concern was also noted around assumption by staff that reduced working week arrangements were the same across all Boards, stressing that each Board's Area Partnership Forum may have different agreements and it's essential everyone follows their own Board's process.

Alignment of implementation with eRostering was discussed with a caveat noted around management of nursing rosters and potential risk of creation a two-tier system. It was proposed that a generic approach, supported by test rosters, would help maintain stability and fairness across the organization.

Following discussion, the APF agreed to implement the reduced working week from the 30 March aligning with the erostering system. It was also agreed that a summary of principles, governance, and communication would be brought back to the Area Partnership Forum for assurance.

Action: Elaine Macdonald/Kevin Reith

8. ANY OTHER COMPETENT BUSINESS

No items were raised.

9. DATE OF NEXT MEETING

The next meeting would be held on Tuesday 24 February 2026 @ 2 pm

Minute of the **Clackmannanshire & Stirling Integration Joint Board meeting** held on **Wednesday 26 November 2025 in the Boardroom, Carseview House, Stirling and hybrid via MS Teams**

PRESENT

Voting Members
Councillor Scott Farmer, **(Chair),** Stirling Council
Councillor Rosemary Fraser, Stirling Council
Councillor Martin Earl, Stirling Council
Councillor Fiona Law, Clackmannanshire Council
Councillor Janine Rennie, Clackmannanshire Council
Councillor Martha Bennie, Clackmannanshire Council
John Stuart, Non-Executive Board Member, NHS Forth Valley
Finlay Scott, Non-Executive Board Member, NHS Forth Valley
Stephen McAllister, Non-Executive Board Members, NHS Forth Valley
Clare McKenzie, Non-Executive Board Member, NHS Forth Valley
Martin Fairbairn, Non-Executive Board Member, NHS Forth Valley

Non-Voting Members
Joanna Macdonald, Interim Chief Officer
Natalie Masterson, Third Sector Representative, Stirling
Helen Macguire, Service User Representative, Clackmannanshire
Andy Witty, Carer Representative, Clackmannanshire
Moira Carmichael, Carer Representative, Stirling
Jennifer Rezendes, Chief Social Work Officer, Stirling Council
Robert Clark, Employee Director, NHS Forth Valley
Kevin McIntyre, Union Representative, Clackmannanshire
Abigail Robertson, Union Representative, Stirling
Anthea Coulter, Third Sector Representative, Clackmannanshire
Dr Kathleen Brennan, GP Clinical Lead, HSCP
Lorraine Robertson, Chief Nurse HSCP
Mike Evans, Localities Representative
Sharon Robertson, Chief Social Work Officer, Clackmannanshire Council
Eileen Wallace, Service User Representative, Stirling

Standards Officer
Lee Robertson, Senior Manager Legal & Governance and Monitoring Officer Clackmannanshire Council

In Attendance
Jennifer Borthwick, Director of Psychological, Mental Health & Learning Disability Services
Wendy Forrest, Head of Strategic Planning and Health Improvement
Ross Cheape, Head of Service, Mental Health & Learning Disability Services
Judy Stein, Interim Head of Community Health and Care
Nikki Bridle, Chief Executive, Clackmannanshire Council
Lindsay Sim, Chief Finance Officer, Clackmannanshire Council

1. APOLOGIES FOR ABSENCE

Councillor Farmer explained any questions/queries raised by IJB members prior to the meeting had been responded to or would be covered within the presentation of papers.

Apologies for absence were noted on behalf of:

Andrew Murray, Medical Director, NHS Forth Valley
Allan Rennie **(Vice Chair),** Non-Executive Board Member, NHS Forth Valley

2. NOTIFICATION OF SUBSTITUTES

None

3. DECLARATIONS OF INTEREST

None

3a. ITEMS OF URGENT BUSINESS

Publishing of IJB Papers

Councillor Farmer reported that Councillor Gibson had submitted a complaint regarding the failure to publish the Integration Joint Board (IJB) papers on the Health and Social Partnership (HSCP) website three clear days prior to the meeting, as required by section 8.4 of the Standing Orders.

It was noted that the established practice had been to publish the papers on the Monday preceding the Wednesday meeting. The Board acknowledged this constituted a breach of Standing Orders and agreed to proceed with the meeting in accordance with section 8.2 of the Standing orders.

Extension of Voting Rights to Non-Voting Members

Councillor Farmer noted that a response to the Scottish Government's consultation, which suggests expanding IJB voting rights to include members with lived experience, service users, unpaid carers, and representatives from the third sector, is required by 5 December 2025.

Councillor Farmer concluded there were no strong objections, but questions were raised from members as regards how the extension of voting rights would take shape with regards to potential additional public scrutiny and the scope of any possible extension. It was planned that this would be addressed by means of a working group. Councillor Farmer advised that anyone interested was encouraged to intimate to officers that they would like to be considered to be part of that working group.

4. DRAFT MINUTE OF MEETING HELD ON 13 AUGUST 2025

The draft minute of the meeting held on 13 August 2025 was approved.

5. ACTION LOG

The action log was approved.

6. HSCP LEADERSHIP AND STAFFING UPDATE

The IJB considered the paper presented by Joanna Macdonald, Interim Chief Officer

Ms Macdonald acknowledged there had been a period of uncertainty and explained that recruitment for the Interim Chief Officer role was underway.

Ms Macdonald thanked the Chief Finance Officers (CFOs) of the constituent authorities for their continued support. She confirmed ongoing efforts are being made to recruit a permanent CFO, and in the meantime, an agency CFOwill temporarily fill this role.

Councillor Farmer noted that assigning specific people to these positions is essential for meeting statutory requirements.

Ms Macdonald formally acknowledged Ms Stein for her contributions as interim Head of Community Health and Care, noting that this position has now been filled on a permanent basis. She also extended her recognition to Liam Gallagher, who has taken on the role of locality manager in Clackmannanshire.

The Integration Joint Board:

1) **Noted the appointment of the permanent Head of Community Health and Care.**
2) **Noted the appointment of the Locality Manager, Clackmannanshire.**

7. IJB MEMBERSHIP

The IJB considered the paper presented by Wendy Forrest, Head of Strategic Planning and Health Improvement.

The Board expressed its appreciation to Gordon Johnston upon his resignation from the Clackmannanshire and Stirling IJB and formally welcomed Clare McKenzie and Finlay Scott to their roles as Non-Executive Board Members, NHS Forth Valley.

They thanked Councillor David Wilson for his work as IJB Chair and welcomed Councillor Scott Farmer as the new Chair.

The Integration Joint Board:

1) **Noted the resignation of Gordon Johnston from the Clackmannanshire and Stirling IJB and welcomed Clare McKenzie and Finlay Scott as non-executive board members.**
2) **Noted membership changes as set out in section 4.**

8. CHIEF OFFICER UPDATE

Ms Macdonald provided a verbal update to the Integrated Joint Board.

Ms Macdonald emphasised the successful collaboration among organisations related to the integration scheme. A meeting has been set with CFOs to discuss the sole expected point of contention: the risk sharing arrangements.

Ms Macdonald advised of the deterioration evident to the partnership's financial position which was due to be discussed later in the meeting.

Ms Macdonald advised of an unannounced Care Inspectorate visit to the Bellfield Centre, Stirling which noted that all core assurances were met with no further inspection required. Areas for improvement included clarity on patient and service user spaces and considerations around the BellfieldCentre role as a health and social care environment.

Ms Macdonald reflected on the Recovery Work Scotland event held in Stirling on 27 September at which she was invited to speak and emphasised the importance of listening to individuals' recovery journeys and the support provided by local organisations.

9. COMMISSIONING OF SERVICES FOR UNPAID CARERS

The IJB considered the paper presented by Wendy Forrest, Head of Strategic Planning and Health Improvement, for decision with direction.

Ms Forrest advised that the paper related to the need to issue a Direction to Clackmannanshire and Stirling Council regarding the delivery of carer services. Ms Forrest noted that the IJB's role is to commission services across Clackmannanshire and Stirling and advised the paper outlines the responsibilities of both councils and the NHS to procure on behalf of the HSCP. Ms Forrest clarified it was a technical paper intended to support council colleagues in proceeding with procurement for Once for Clackmannanshire and Stirling Carers Service, which is intended to replace the two separate care commissioning services that currently exist in the Stirling and Clackmannanshire local authority areas.

Ms Forrest advised that, under procurement legislation, the partnership could not anticipate which provider would be successful with any contract for a commissioned service. She offered to bring a paper to a future meeting towards the end of the financial year providing more detail.

The Integration Joint Board:

1) **Approved the advancement of the process to procure based on the specification.**
2) **Agreed the Direction annexed at Appendix 1**.

10. FINANCIAL REPORT

The IJB considered the paper presented by Lindsay Sim, Chief Financial Officer, Clackmannanshire Council.

Ms Sim reported that the integrated budget across NHS Forth Valley, Stirling Council, and Clackmannanshire Council is £254.4 million, with a forecast expenditure of £265.2 million, resulting in a projected overspend of £10.9 million. Ms Sim advised further that the set aside budget for large hospital services was under pressures from factors such as urgent care, staffing, agency costs, and prescribing. Progress on the delivery plan continues, with savings expected later in the year. A review of reserves is underway to offset the overspend.

The 2024/25 overspend of £6.9 million has been resolved through partner contributions, with Clackmannanshire's share to be repaid in 2026/7. Risks remain due to delayed UK and Scottish budgets and uncertainty around local government settlements, including potential impacts from corrections to adult social care indicators.

Members raised concerns about financial clarity, technical accountancy terminology used to describe Clackmannanshire's contribution, and realisability of savings. Ms Sim confirmed reserves will be reviewed by partner CFOs. As regards accountancy requirements on a loan, Ms Sim advised in response to member queries that this is not technically a loan under accountancy rules but a repayment of funds. Ms Sim advised that the technical explanation for this would be included in the year end accounts. Savings on the delivery plan are also to be realised in the latter part of the year. Ms Macdonald highlighted positive progress, including inpatient redesign and reducing care home admissions, but acknowledged national funding challenges.

Councillor Farmer stated that unresolved actions will be reviewed at the Finance, Audit and Performance meeting on 14 January 2026 and the next meeting of the Integration Joint Board on 28 January 2026.

The Integration Joint Board:

1) **Noted the revised final 2024/25 Financial Year Outturn, subject to conclusion of the statutory audit and the expected timing of approval of the Audited Financial Accounts for 2024/25 (section 2).**
2) **Noted the projected overview at Month 6 and narrative on areas of material variance (Section 3).**
3) **Noted that further traction is required on the delivery plan to mitigate the projected overspend (Section 3.4)**

11. ADP UPDATE: NATIONAL DRUGS MISSION

The IJB considered the paper presented by Wendy Forrest, Head of Strategic Planning and Health Improvement.

Ms Forrest presented a paper summarising two years of planning linked to National Drug Mission funding, initiated in 2021. The work is moving toward a more community-focused system of care with visible third sector involvement. She acknowledged the challenges and potential impact on staff and urged the IJB to remain mindful of these implications.

Mr Cheape highlighted the complexity of the proposal, noting growing demand across services and the need to weigh risks carefully when reassigning funds as it was likely to lead to divestment elsewhere.

Ms Forrest clarified that the paper reflects the Scottish Government's proposed framework for Alcohol and Drug Partnerships (ADP), which will include alcohol issues, though uncertainty remains around the National Drugs Mission.

The Integration Joint Board:

1) **Noted the progress made across system of care following previous IJB decisions.**
2) **Agreed the delivery of ADP partners' Strategic Direction in relation to substance use care, support and treatment is required by the Partnership Delivery Framework. This will ensure continued transformational commissioning focused on the planning around the end of the National Drugs Mission funding.**
3) **Noted the role of the Lived Experience Advisory Panel, and their continued commitment to support the ADP.**

12. QUARTER 2 PERFORMANCE REPORT

The IJB considered the paper presented by Wendy Forrest, Head of Strategic Planning and Health Improvement.

Ms Forrest presented this standard quarterly report on the Strategic Commissioning Plan, noting gaps previously highlighted. The report aims to ensure robust data collection across delegated services.

Dr Borthwick responded to a prior query from Councillor Rennie regarding psychological therapies, assuring that individuals referred to psychology have options beyond digital therapies. Over the past year, 2,365 people started evidence-based digital therapy, alongside 33,754 individual or group appointments. Ms Forrest, confirmed imminent plans for the commissioning of dementia services, including post-diagnostic support, with a draft contract prepared.

The discussion highlighted positive developments in service redesign and commissioning but acknowledged ongoing challenges with data systems and the need for clearer alignment between performance reporting and strategic objectives.

The Integration Joint Board:

1) **Reviewed the Quarter Two (July to September 2025) Performance Report.**
2) **Noted the areas where actions have been taken to address the issues identified where performance needs to be improved.**
3) **Approved Quarter Two (July to September 2025) Executive Summary (Appendix 1) & Report (Appendix 2).**

13. REVIEW OF THE STRATEGIC COMMISSIONING PLAN

The IJB considered a paper presented by Wendy Forrest, Head of Strategic Planning & Health Improvement.

Ms Forrest confirmed the IJB's responsibility for approving the statutory 10-year commissioning plan, which is subject to periodic review. The current paper reflects the agreed approach and ongoing delivery. Representation from constituent organisations and third sector partners was sought for a steering group, with thanks expressed to Ms Masterson and Mr Witty for their contributions. A survey remains open until 03 January 2026, supported by in-person and online sessions providing useful feedback.

The discussion emphasised the need for clear performance measures, robust governance, and effective communication to ensure alignment with strategic objectives.

The Integration Joint Board:

1. **Considered and noted the progress for reviewing the Strategic Commissioning Plan 2023 - 2033.**
2. **Noted the engagement process commenced on 3rd November and is in progress across system.**

3. Considered proposed Key Performance Indicators linked to Strategic Planning priorities.

14. UPDATE ON PROGRESSING HEALTH & SOCIAL CARE THROUGH THE IJB IN CLACKMANNANSHIRE & STIRLING

Ms Macdonald reflected on progress since assuming the Interim Chief Officer role, noting that her predecessor's paper, presented at the IJB on 19 June 2024, highlighted concerns about relationships across the system. She stated that constructive, open discussions have strengthened collaboration between constituent organisations. She emphasised the uniqueness of the IJB being comprised of two local authorities and highlighted Audit Scotland's recognition of both progress and challenges. Development sessions have been reintroduced, and while progress on the integration scheme has been limited, the IJB continues to work toward a unified approach for Clackmannanshire and Stirling.

During the discussion concerns were raised about risk-sharing arrangements, stressing that responsibility lies with constituent authorities and suggesting escalation to the Scottish Government if parity cannot be achieved before year-end. Ms Macdonald confirmed a draft integration scheme, including risk-sharing, is expected shortly and will be reviewed with CFOs, and clarified that the Scottish Government had not ceased to be involved since the initial dispute between the constituent organisations.

The Integration Joint Board:

1) Considered the content of this report.

15. PRINCIPLES & GOVERNANCE OF HOSTED SERVICES

The IJB considered the paper presented by Wendy Forrest, Head of Strategic Planning & Health Improvement.

Ms Forrest explained that the paper was jointly developed with colleagues from Falkirk HSCP and aims to clarify principles and governance related to hosted services.

Ms Forrest explained that specialist mental health services are hosted by the Clackmannanshire and Stirling HSCP on behalf of all providers, while Prison Healthcare and Primary Care are both managed by Falkirk HSCP on behalf of all providers.

Ms Forrest confirmed that this paper had already been noted and approved by the Falkirk IJB on 31 October 2025. She advised that the version presented is the same in terms of content to those papers.

The Integration Joint Board:

1) **Noted the outlined principles and governance arrangements relating to Hosted Services within Clackmannanshire and Stirling IJB.**

16. INFORMATION GOVERNANCE REPORT

The IJB considered the paper presented by Sarah Hughes-Jones, Head of Information Governance.

Ms Hughes-Jones advised she was in attendance to provide assurancearound the Board's compliance with data protection, records management andfreedom of information legislation. This assessment is specific to the records and information belonging to the IJB itself. As highlighted in previous reports,the IJB processes limited records and information, with most processes undertaken by either the health board or local authorities. Ms Hughes-Jones advised that the IJB is supported by the processes which are in place by the partner organisations and can consequently be reasonably assured thatproper arrangements are in place.

Ms Hughes-Jones advised that, as reflected in the report, the current arrangements are in place to meet requirements under data protection and records management legislation are working well and there are no areas of significant concerns to highlight at this time. In terms of access to information legislation and access, NHS Forth Valley processes Freedom of Information (FOI) requests received by both Clackmannanshire and Stirling and Falkirk IJBs.

Ms Hughes-Jones reported on the work undertaken by NHS Forth Valley to improve FOI performance in respect of the Level 3 intervention from the Scottish Information Commissioner; compliance is now above 90% though NHS Forth Valley remains under intervention.

Following discussion, the Board agreed that “broadly” was unnecessary in section 3.1 and decided the wording should instead confirm that the procedures in place are appropriate as required.

The Integration Joint Board:

1) **Considered and approved the Information Governance activity for the year 2024/2025.**

17. STRATEGIC RISK REGISTER

The IJB considered the paper presented by Ross Cheape, Head of Service for Mental Health & Learning Disabilities.

Mr Cheape advised the Strategic Risk Register remained unchanged from when it was last presented it at the meeting on 13 August 2025. The IJB was asked to approve its move to an electronic risk management system.

The details of what it will involve and look like will be presented to the Finance, Audit and Performance Committee on 14 January 2026 before being presented to the IJB at the meeting on 28 January 2026

After discussion, it was noted that the full board continues to scrutinise the Strategic Risk Register. The Finance, Audit and Performance Committee have a delegated role to oversee proposals, but this does not delegate the responsibility of the board to review them.

The Integration Joint Board:

1) Approved the plan to move the Strategic Risk Register on a Risk Management System, and seek endorsement from the Finance, Audit and Performance Committee in December.

18. REVIEW OF SCHEME OF DELEGATION

The IJB considered a paper presented by Wendy Forrest, Head of Strategic Planning & Health Improvement.

Ms Forrest presented the updated Scheme of Delegation for approval, noting it reflects prior discussions. In response to Councillor Law's concerns about ensuring services can be delivered within planned budgets, Ms Forrest clarified that financial costings aligned to Directions are expected to be completed before papers reach the board.

The discussion reinforced the need for clear governance, financial assurance, and process transparency to support decision-making and maintain accountability.

The Integration Joint Board:

1) Considered and discussed the contents of the report.
2) Approved the Scheme of Delegation.
3) Noted the background to the extant Scheme of Delegation.
4) Agreed that the Scheme of Delegation is further reviewed when a revised Integration Scheme is approved and on a bi-annual basis.
5) Noted that any revisions to the Scheme of Delegation require the approval of the Board.

19. IJB, COMMITTEE & STRATEGIC PLANNING GROUP DATES 2026/2027

The IJB considered a paper presented by Wendy Forrest, Head of Strategic Planning & Health Improvement.

Ms Forrest advised this was a standard paper agreed on an annual basis outlining the proposed dates for the IJB, Finance, Audit and Performance Committee and the Strategic Planning Group, which are the three functioning statutory groups, aligned within the IJB.

The Integration Joint Board:

1) Noted the content of the paper.
2) Approved the proposed Integration Joint Board programme of meeting dates for 2026 / 2027 set out in paragraph 2.1.
3) Approved the proposed Integration Joint Board Finance, Audit and Performance Committee programme of meeting dates for 2026 / 2027 set out in paragraph 3.1.
4) Approved the Strategic Planning Group programme of meeting dates for 2026 / 2027 set out in paragraph 4.1.

20. FUTURE MODEL OF PLANNED BED BASED RESPITE THROUGH CLACKMANNANSHIRE & STIRLING

The IJB considered a paper presented by Judy Stein, Interim Head of Community Health & Care.

Ms Stein presented an update on the development of the Future Model of Planned Bed-Based Respite) for Clackmannanshire and Stirling, noting that a paper with decision with Direction will be brought to the next IJB meeting following a six-week stakeholder engagement process.

She highlighted risks, including staff wellbeing during this period of uncertainty, and confirmed that the £148,000 savings identified in the delivery plan would not be achievable within the current financial year.

The discussion noted that timing and communication around sensitive and difficult decision making was important, including with elected members and communities as part of every process.

The Integration Joint Board

1) Noted the progress that has been made with the recent completion of the planned six-week stakeholder engagement process.
2) Noted the intention to complete the work required to present a consultation 'responses' report and a comprehensive IJB report for decision with Direction to the next appropriate IJB meeting.

21. NHS FORTH VALLEY POPULATION HEALTH & CARE STRATEGY 2025 – 2035

The IJB considered a paper presented by David Munro, Senior Planning Manager, NHS Forth Valley.

Mr Munro presented the engagement summary for the Population Health & Care Strategy 2025–2035, highlighting extensive service user and staff input prior to formal engagement. He emphasised that the current system of care is unsustainable and that maintaining population health requires more than healthcare delivery. The strategy sets out an ambitious 10-year framework focused on prevention, early intervention, tackling inequalities, and shifting care closer to home through community-based models. It also prioritizes value-based health and care and workforce development to ensure sustainability and high-quality care.

The strategy was approved by the NHSFV Board on 29 September 2025, with a summary document available on the intranet. Engagement feedback led to revisions, and next steps will focus on implementation.

The discussion reinforced the strategy's transformative intent, its focus on prevention and community care, and the importance of embedding participation and cultural change.

The Integration Joint Board:

1) **Noted the content of the Forth Valley Population Health & Care Strategy (2025 – 2035), the feedback received during the engagement process, the national policy direction and the results of the equality impact assessment.**
2) **Considered any future implications.**

22. ANY OTHER COMPETENT BUSINESS (AOCB)

The Board thanked Ms Macdonald for her service as Interim Chief Officer and wished her well in her new role.

23. DATE OF NEXT MEETING

28th January 2026

Falkirk
Health and Social Care
Partnership

Minute of hybrid meeting of the Integration Joint Board held within **Grangemouth Community Education Unit, 69-71 Abbots Road, Grangemouth, FK3 8JB** and **remotely** on **Friday 5 December 2025** at **9.30 a.m.**

Voting Members:	Councillor Fiona Collie Councillor Jim Flynn Councillor Anne Hannah Alison Jaap Gordon Johnston (Chair) Stephen McAllister
Non –voting Members:	Marie Keirs, Chief Finance Officer (Items IJB55, IJB56, IJB58 & IJB60) Sara Lacey, Head of Social Work Children's Services/Chief Social Work Officer David McNiven, Service User Representative Victoria McRae, Third Sector Interface Amanda Winters, Carer Representative (Substitute) Roger Ridley, Staff Representative, Falkirk Council Gail Woodcock, Chief Officer (Items IJB54 & IJB62)
Also Attending:	Claire Chapman, Home First Manager (Item IJB60) Tom Cowan, Head of Strategic Planning & Transformation Caroline Doherty, Head of Community Services (Items IJB57, IJB59 & IJB61) Kenny Gillespie, Head of Communities, Innovation & Housing (Item IJB57) Jack McLay, Democratic Services Graduate Jim Millar, Team Leader – Committee Services Gordon Mackenzie, Locality Services Lead (Item IJB59) Ewan Murray, Business & Governance Lead James Paterson, Policy & Research Officer (Item IJB59) Paul Surgenor, Communications Officer (Item IJB60) Carly Toland, Committee Officer Cheryl White, Falkirk HSCP Support Officer Nicola Wood, Chief Nurse

IJB50. Apologies

Apologies were submitted on behalf of Sharon Mwale.

Amanda Winters was attending as a substitute for Sharon Mwale.

IJB51. Declarations of Interest

There were no declarations of interest.

IJB52. Minute

Decision

The Integration Joint Board approved the minute of the meeting held on 31 October 2025.

IJB53. Action Log

An action log detailing ongoing and closed actions following the previous meeting on 31 October 2025 was provided.

Items IJB11 and IJB29 were the subject of reports on the agenda and subsequently fell as closed actions on the rolling action log.

Decision

The Integration Joint Board noted the Action Log.

IJB54. Chief Officer Report

The Board considered a report by the Chief Officer highlighting current developments locally, regionally, and nationally which were likely to be of interest to Board members.

The Board requested further information in relation to the Market Facilitation Plan and what implications this would have for services in Falkirk. The Chief Finance Officer advised that this was being updated in line with the Strategic Plan and was still in its early stages. The Market Facilitation Plan would take into account market conditions and the current financial climate.

The Board asked for further information on the additional funding announced for General Practices. The Head of Strategic Planning & Transformation advised that the detail of what this funding could be used for was not yet available, but it was likely that the benefits would flow through to Primary Care. As a follow-up question, the Board noted that there was a funding allocation of around £249m for Scotland, and asked what proportion of this would come to Falkirk. The Head of Strategic Planning & Transformation advised that, assuming the usual National Resource Allocation formula was being used, around £6m would be

allocated to Forth Valley, however he noted that there was not yet certainty that this formula would be used.

The Board asked about the work being undertaken in relation to Transformation through Collaboration. The Chief Officer explained that Falkirk already hosted prison healthcare and Primary Care services so this work was not unfamiliar. She assured the Board that any proposals in relation to Transformation through Collaboration which were under the IJB's delegated powers would come to the IJB for approval.

Decision

The Integration Joint Board:-

(1) noted the re-appointment of Andrew Murray, Medical Director, Karen Goudie, Executive Nurse Director and David Herron, GP Clinical Lead as non-voting members of the IJB for the 3-year period to December 2028;

(2) noted the information provided at section 4.9 of the report regarding the third sector representative position, with an update on an appointment to be provided in due course.

(3) approved the appointment of Alison Jaap to the Performance, Audit and Assurance Committee as a voting member; and

(4) noted the report being presented to Falkirk Council on 27 November entitled 'Transformation through Collaboration', endorse the intention to explore opportunities through collaboration to support sustainability and agree that the IJB receives further progress updates and specific reports on this subject in due course.

IJB55. IJB Business Case and Medium-Term Financial Plan Update

The Board considered a report by the Chief Finance Officer which provided an updated position to the IJB on the budget pressures and assumed funding for the 2026/27 Revenue Budget and the 5-year medium-term financial plan to 2030/31.

The Board requested further information on the set aside budget. The Chief Finance Officer explained that the set aside budget was in relation to large hospital services. She explained that this fell under the delegated powers of the IJB, but it had been challenging for all IJBs to track and understand the activity behind these areas in order to influence spend. She noted that any projected overspend in this area was covered by NHS Forth Valley at the end of the year.

The Board asked about the outcome of discussions between COSLA and the Scottish Government about the overall funding position of IJBs. The Chief Finance Officer advised that COSLA had written to the Scottish Government and a meeting had taken place, but the outcome of this was not yet known. She noted that it was not anticipated that any additional funding would be available.

The Board noted improvements in the financial position since the last update, but raised concerns around multi-year pressures and how these would be addressed in the long-term. The Chief Finance Officer advised that a sensitivity analysis would be brought to the January 2026 meeting of the IJB which would address these concerns.

The Board requested further information in relation to pay uplifts and job evaluations. The Chief Finance Officer advised that additional funding from the Council had been allocated for the additional 1% pay uplift during the 2024/25 financial year. She noted that current planning assumed this funding to be recurring. She noted that the settlement from the Scottish Government would be announced later than usual, and she was working closely with the Council's Chief Finance Officer around the planning of assumptions. In relation to job evaluations, the Chief Finance Officer advised that early discussions were still taking place, and the sensitivity analysis would provide further information on this. Information regarding the number of job evaluations would be provided following the meeting.

The Board asked for further information on training for care providers and the involvement of carers in hospital discharge. The Chief Finance Officer advised that, under the Care and Support at Home Framework, care providers were required to go through a standard vetting process and adhere to set regulations in relation to training. The Head of Community Services advised that there was a view to operate an integrated discharge service which involved carers, and it was anticipated that a short life working group would be established to drive this work forward.

Decision

The Integration Joint Board noted the funding pressures set out in the paper, and risks identified at Section 5 of the report, and the actions required and carried out to date to bring forward the 2026/27 business case and MTFP.

Victoria McRae joined the meeting during consideration of the following item.

IJB56. Budget Monitoring Report December 2025/26

The Board considered a report by the Chief Officer presenting a high-level summary of the current 2025/26 projected financial position including consideration of risks to the financial position.

The Board requested further information regarding the underspend within Community Services and the impact of this underspend on services. The Chief Finance Officer advised that the main reason for the underspend in this area was vacancies, and this was mostly due to natural turnover of staff and recruitment and retention issues. She noted that there was a vacancy panel which met on a weekly basis to review any gaps in services and ensure safe staffing levels are maintained.

The Board asked for assurance on the effectiveness of residential care allocations. The Chief Finance Officer advised that measures were in place to manage this, including the return to a risk-based approach, and a resource allocation panel met weekly to monitor and review this.

The Board asked about the implications of having insufficient contingency reserves to pump prime any potential spend to save initiatives. The Chief Finance Officer advised that the reduction in available reserves meant there were less funds available for one-off spend to save initiatives, but this would be built into the budget and the medium-term financial plan as an additional pressure on a one-year basis.

The Board requested an update on prescribing. The Chief Finance Officer advised that there was an annual prescribing improvement initiative where improvement actions were reviewed. She also noted that there was a plan to address the overspend in prescribing by building in a 5.5% increase into budget assumptions. The Head of Strategic Planning & Transformation advised that there were many factors outwith the Board's control in relation to prescribing, such as international markets, but Forth Valley had a good reputation in terms of its prescribing policies.

The Board noted the various terms referred to within the report in relation to care and requested a glossary which provided an overview of their definitions. The Chief Finance Officer advised that this would be circulated to members following the meeting.

Decision

The Integration Joint Board:-

(1) noted the current projected position for integrated budgets and set aside services;

(2) noted the non-recurring reserves position set out in Appendix 5 of the report; and

(3) authorised the Chief Officer to issue revised Directions to Falkirk Council and NHS Forth Valley as per the Directions provided at Appendix 6 of the report.

The Board adjourned at 10:35am and reconvened at 10:50am.

Stephen McAllister left the meeting during consideration of the following item.

IJB57. Housing with Care – Motion Response

The Board considered a report by the Head of Community Services outlining the response to the Housing with Care (HWC) motion agreed at the meeting of the IJB on 5 September.

A member of the Board expressed concerns around the consultation and the options appraisal that preceded the decision to reprovision care at Tygetshaugh complex. There were particular concerns raised in relation to the criteria used to assess each HWC complex. The Head of Community Services advised that a draft version of the options appraisal was circulated to consultees for comment, who were Trade Union representatives, Housing Services staff, Human Resources staff, and management representatives. She highlighted that there were two further opportunities for consultees to provide feedback on the options appraisal, and no feedback was received. She noted that every effort was made to involve and collaborate with consultees as much as possible.

The Board asked for clarification on the difference between HWC and Care at Home. The Head of Community Services explained that individuals with assessed eligible care needs received Care at Home support, this was provided by a Care at Home service. HWC was a provider of Care at Home and a care service registered with the Care Inspectorate. She noted that the HWC model had been in place for over 40 years. Service demand and resources had shifted and there was now capacity to support people with complex needs to stay at home and live independently for as long as possible

The Board asked about the complexity of needs of people within HWC complexes. The Head of Community Services advised that, of the four HWC complexes, tenants at Tygetshaugh had the lowest overall level of need. She explained that an updated Eligibility Criteria was agreed at IJB earlier that year, and the level of need for the HSCP to deliver a care service had to be substantial or critical. In response to a follow-up question, the Head of Community Services advised that 80% of care in Falkirk was delivered by private or third-sector providers.

The Board asked about the process of reassessment for recipients of HWC services. The Head of Community Services advised that the assessment

tool previously used to assess service-users was deemed no longer appropriate and, as part of an improvement programme for HWC properties, additional resources were allocated to ensure all service-users had an updated, outcome-focused assessment in place. She noted that this process was unrelated to the reprovisioning process at Tygetshaugh. She explained that the reassessment process took place at different paces depending on the HWC complex and the availability of resources, and this was supported by the social work teams. To avoid repetition of past practices, resources were triaged to prioritise new service-users to ensure every service-user had a robust assessment in place. She noted that the pace of the reassessment process in each HWC complex was different, but everyone receiving a HWC service across the four complexes had now been assessed. Following a further question around the reassessment process, the Head of Community Services advised that service-users would have their assessments reviewed on a 6-monthly basis going forward.

The Board requested further information on comments made in relation to excess capacity within HWC facilities. The Head of Community Services explained that, while there was a requirement to have additional needs, there was no requirement to have eligible care needs in order obtain a tenancy at a HWC property. She noted that the demand within each complex was different depending on the model of care provided, meaning the capacity was also different. Across all 4 complexes there was capacity to provide more care than was currently required. The Head of Community Services also highlighted that under the Social Care (Self-directed Support) (Scotland) Act 2013, people were entitled to choose how their care was provided, so their care package was not tied to their tenancy in a HWC complex.

The Board asked for clarity on the allocation process for HWC tenancies. The Head of Communities, Innovation & Housing advised that the allocation of tenancies in Scotland sat solely with the local authority's Housing service.

The Board asked about contingency planning for service-users during the reprovisioning process. The Head of Community Services advised that a dedicated worker from the social work team worked with service-users to develop individual contingency plans where there were potential issues with capacity. She noted that contact would be made with service-users whose care would be transferred to identify any issues and provide support, and their care package would be formally reviewed after 6 weeks. In response to a question about the number of care providers within the Care at Home framework, the Chief Finance Officer advised that there were approximately 80 providers.

Following a question about how the options appraisal was scored, the Head of Community Services advised that each complex was ranked against five objectives, which were: financial efficiencies, complexity of care, quality of care, potential for development and adaptability of the environment.

The Board asked about the feedback from staff and service-users during the reprovisioning process. The Head of Community Services advised that this had been a challenging process, and some staff and service-users had expressed feelings of uncertainty and pressure. She provided assurance that every effort was being made to address concerns and support individuals, and service-users had a named individual who would remain attached to them throughout this process.

Following a question about how this work would be overseen, the Head of Community Services advised that the Transformation Board had oversight of this process and a report had been brought to the Performance, Audit & Assurance Committee for consideration.

The Board asked about the average response time for the Mobile Emergency Care Service (MECS). The Head of Community Services advised that further information would be provided on this following the meeting. In response to a question, the Head of Community Services explained that MECS used a prioritisation matrix to triage the level and timing of responses, depending on an individual's unique care plan. She noted that additional staff had been allocated to MECS and safe staffing levels were monitored on a weekly basis.

Decision

The Integration Joint Board noted the report.

IJB58. IJB Strategic Risk Register

The Board considered a report by the Chief Finance Officer which provided an update on the IJB Strategic Risk Register. No new risks had been added to the main register since the last version presented to Performance Audit and Assurance Committee on 26 September 2025. There were currently 9 live risks recorded in the register, 1 was considered very high risk, 7 were high risk and 1 was medium risk.

The Board asked whether there was scope to take a more proactive, strategic approach to the risk register in the future. The Chief Finance Officer advised that the Business and Governance Lead was now in post and would be taking forward work in relation to risk.

The Board asked about the main hurdles being faced by the IJB in managing its risks. The Chief Finance Officer advised that there were hurdles in relation to capacity to take forward reviews as well as the national funding position. She noted that there was extensive work ongoing to mitigate risks, but these had remained static due to these challenges.

The Board noted a number of risks which were assessed as 'High' but had a target of 'Low,' and the likelihood of achieving this. The Chief Finance Officer advised that there was work ongoing to ensure that targets were

reasonable and proportionate, and this would be brought back to IJB for consideration in due course.

Decision

The Integration Joint Board noted the:-

(1) high-level summary of the IJB Strategic Risk Register presented at section 4.7 of the report;

(2) detailed IJB Strategic Risk Register at Appendix 1 of the report;

(3) ongoing work in relation to the changes proposed and reported to PAAC in June 2025 per Appendix 3 of the report;

(4) position set out in the action plan arising from the annual risk review presented to the Performance, Audit and Assurance committee in September 2025, shown in Appendix 4 of the report; and

(5) inclusion of the Children and Families Corporate risk register to provide overview to the Committee pending finalisation of the Integration Scheme.

IJB59. Falkirk HSCP Locality Planning Update

The Board considered a report by the Head of Community Services which provided an update on the Falkirk HSCP Locality Planning Process to date.

The Board provided feedback on the West Locality Plan. The Chief Officer advised that the Board's comments would be considered and incorporated as the Plan was progressed and refined. She added that a new Strategic Plan was in development for 2026 which the Board would also have the opportunity to provide feedback on.

Decision

The Integration Joint Board approved the Falkirk HSCP West Locality Plan and Delivery Plan.

IJB60. Communications & Engagement Update

The Board considered a report by the Chief Finance Officer providing a summary of communications and engagement activity undertaken during July - Sept 2025.

The Board provided feedback on how the communications and engagement update was reported. The Communications Officer advised that these comments would be taken forward for future reports.

The Board requested assurance on consultation and engagement processes. The Chief Finance Officer advised that there were extensive lessons learned from Budget consultation which officers were keen to take on board in order to engage as many people as possible, particularly harder-to-reach populations.

Decision

The Integration Joint Board noted the contents of the report.

IJB61. Shifting the Balance of Care Evaluation

The Board considered a report by the Head of Community Services which provided an evaluation of the Shifting the Balance of Care project.

The Committee had the benefit of a presentation and video, which detailed the experiences of patients who had taken part in the project.

The Board noted the positive outcomes of this project and thanked staff for their work in achieving this. The Board asked about the demand in Primary Care services arising from this project. The Chief Officer advised that a business case was currently in development which would review and address this.

The Board asked about the involvement of unpaid carers in hospital discharges. The Home First Manager advised that there was a dedicated worker who facilitated initial discussions around hospital discharges which would involve all the relevant parties in an individual's care, including unpaid carers. The Chief Finance Officer noted that carers would be involved in and consulted on any savings proposals brought forward.

The Board asked whether there would be more rehabilitation staff in community in order to reduce admissions to hospital. The Chief Officer advised that by shifting resources closer to home there should be fewer hospital admissions, and this meant that when hospital admission was the required pathway that there would be appropriate resources in place to meet demand.

The Board asked about the future of this project and its economic impact. The Chief Officer noted that, while still in its early stages, this project had significant potential and had already shown signs of success.

The Board asked for assurance in relation to links between community services. The Chief Officer advised that there was ongoing work to improve

the connection between services, however this was an iterative process and would be addressed as this work develops.

Decision

The Integration Joint Board noted:-

(1) the data and progress made;

(2) the largely positive impact for patients and their carers supported through Shifting the Balance of Care;

(3) the evaluation report attached to the report; and

(4) that a Business Case and Options Appraisal for recurring funding is being progressed.

IJB62. Assurance Report from Performance, Audit and Assurance Committee on 21 November 2025

The Board considered a report by the Chief Finance Officer which sought to provide assurance to IJB on the items considered at the Performance Audit & Assurance Committee held on 21 November 2025.

Decision

The Integration Joint Board noted the Assurance Report produced following the PAAC on 21 November 2025 at Appendix 1 of the report.

NHS Forth Valley

Forth Valley NHS Board

8. Anti-Racism Plan

Purpose: This report is for Decision

Executive Sponsor: Kevin Reith, Director of People

Authors: Linda McGovern, Deputy Director of Workforce; Aileen Love, Head of Occupational Health; Stacey Gourlay, Disability Liaison Officer, and Rachel Tardito, Equality, Diversity and Wellbeing Lead

Executive Summary

Board approval is sought for the NHS Forth Valley Anti-Racism Plan (Appendix 1). The Plan establishes a clear and proportionate approach to addressing racism across the workforce, services, and organisational culture. It is informed by national policy, local data, and lived experience, and is aligned with the Equality Act (2010) and NHS Scotland values.

The Plan has been developed in response to both Scottish Government guidance and a broader recognition of the existence of racism within organisational systems and culture. Discrimination or racism in any form is deemed unacceptable. Persistent racial inequalities in staff experience, leadership representation, workforce processes, and patient outcomes are evidenced, with causes rooted in both individual behaviours and systemic, institutional factors. The Plan advocates a sustained, whole-system approach to deliver meaningful change.

Developed through partnership working and engagement, the Plan is supported by an Equality Impact Assessment (Appendix 3), a delivery tool (Appendix 4), and communications and launch plan (Appendix 5). It outlines an ambitious yet achievable three-year programme of work, underpinned by robust collaboration with the Ethnic Diversity Staff Network, trade unions, and community stakeholders. The Plan is further aligned with existing initiatives, including Culture Change and Compassionate Leadership, and incorporates clear governance, outcomes, and reporting arrangements.

The communications plan is designed to foster staff engagement at all levels, recognising that anti-racism is a collective responsibility. Board approval will signal a clear organisational commitment to becoming an anti-racist organisation, reinforcing trust, improving equity, and ensuring dignity and fairness for staff, patients, and the wider community.

Action Required

The Forth Valley NHS Board is asked to:

(1) approve the NHS Forth Valley Anti-Racism Plan as attached to this report.
(2) approve the Communications Strategy and note that the Staff Governance Committee will oversee reporting going forward.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified

Governance Route to the Meeting and Previous Board Consideration
This matter was considered by the following groups as part of its development and sign off. The groups will be asked to support the content and provide their feedback.

- **Ethnic Diversity Network (EDN) on 3 June 2025 (whole day event), 18th September 2025 (online session), 13 and 15 January 2026 (Anti-Racism Plan update online drop-in sessions)** – feedback around what should be included and prioritised within the plan, including how best to launch, support and measure success, has been discussed at these EDN meetings and events, with feedback incorporated into the Plan.
- **Area Partnership Forum (APF) on 28 October 2025 –** members were provided with a copy of the initial draft for feedback and input.
- **Staff Governance Committee (SGC) on 18 November 2025** – members were provided with a copy of the initial draft Anti-Racism Plan for consideration and input as part of the Equality and Inclusion Strategic Framework update. Feedback has been incorporated into the revised draft for the next governance checkpoint.
- **Senior Leadership Team (SLT) on 24 November 2025** - members were provided with an updated draft Anti-Racism Plan (Version 2.0) for consideration and input. Feedback was incorporated into the revised draft for the next governance checkpoint.
- **SPPRC on 16 December 2025** – members were provided with an updated copy of the draft Anti-Racism Plan (Version 4.0) for consideration and input. Feedback was incorporated into the revised draft for the next governance checkpoint.
- **Area Clinical Forum (ACF) on 15 January 2026** - members were provided with a copy of the draft Anti-Racism Plan (Version 6.0) for consideration and input. Feedback will be incorporated into the revised draft for the next governance checkpoint.

Please note *that additional versions were developed to reflect additional governance feedback and feedback from monthly working group meetings.*

Risk Assessment and Mitigation
Initial considerations of risks have been undertaken and as per the delivery tool (appendix 4), an ongoing risk register will be held and reviewed at regular intervals, with a clear escalation route in place. At this stage, the following risks have been identified as potential barriers to the successful implementation of the Anti-Racism Plan:

1. **Organisational readiness and cultural resistance** – risk that staff and leaders may be uncertain or lack confidence to engage in anti-racist practice, especially when facing the discomfort and challenge of tackling racism and address bias.

2. **Inconsistent implementation** – risk that without a consistent approach to implementation across all departments, areas and service there could be reduced impact and inequity of application and experience of impact.

3. **Reputational risk** - if the organisation is perceived to be inactive or performative in addressing racism, there is a significant reputational risk associated.

Appendix 4, outlines what mitigating actions would be required to help address these corporate risks, including:

•Senior leadership sponsorship and allyship and clear governance routes.
• A phased implementation plan with supporting comms plan that has measurable milestones and regular review.
• Essential anti-racism learning and leadership development embedded within workforce programmes, such as the new Leadership and Management Framework.
• Ongoing partnership with Forth Valley's Ethnic Diversity Network and key stakeholders, including external equality organisations and third sector partners to monitor progress and more importantly provide feedback and challenge when necessary to hold to account.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? Yes
If yes, please confirm this is attached. Attached X Not required ☐

Please refer to Appendix 3 for full EQIA. This illustrates any potential positive or negative impacts resulting from the work associated with our Anti-Racism Plan, with a key focus on intersectionality and the potential risk of additional discrimination as a result of not acknowledging the health inequalities associated with intersectionality. Mitigating actions will form part of our wider approach to implementing the Plan. Some of the key themes identified include:

- Improving equitable access to services and information through targeted interpretation and translation support, alongside non-digital routes to avoid exclusion for those affected by age, disability, poverty or limited English.
- Strengthening safe, culturally competent and trauma-informed reporting mechanisms, together with anti-racism and intersectionality-focused training, to address under-reporting and compassionately challenge bias.
- Inclusive leadership and fair workforce processes, including bias-aware recruitment, transparent people management and targeted development for minority ethnic colleagues.
- To ensure services are responsive and trusted, the Plan embeds co-designed, culturally competent pathways, improved ethnicity-disaggregated data, collaboration with staff networks and community partners, and faith- and socio-economic-aware approaches. Ongoing engagement and feedback loops will support continuous improvement and reduce the risk of disengagement among marginalised and easy-to-miss groups.

Financial and Infrastructure Implications
Whilst there are no specific budget or direct cost implications for the Plan, there is the acknowledgment that investment may be required to support particular key actions, which will be absorbed within current budgets aligned to the area of work. This would include examples such as digital infrastructure updates to improve data collection and reporting on ethnicity and experience metrics. Where this is not

feasible, support will be sought from the Director of Finance to explore alternative solutions. A positive return on investment is anticipated for any capital spend as evidence denotes that the implementation of an effective Anti-Racism Plan is both an ethical and economic investment, improving workforce stability, service quality, and financial sustainability (Donner and Miller, 2006).

Workforce Implications
The Anti-Racism Plan can deliver clear workforce benefits for the organisation, including but not limited to:

- Lower staff turnover – tackling racism improves retention.
- Reduced sickness absence – a fair, inclusive culture improves wellbeing.
- Fewer employee relation cases and people processes – proactive prevention and early resolution reduce costly grievances and potential tribunals.
- Higher productivity – diverse, psychologically safe teams perform better.
- Improved patient outcomes – better staff experience links to safer, higher-quality care and fewer complaints.
- Enhanced reputation – trusted, inclusive organisations attract talent, partnerships, and funding, especially in relation to attracting future generations to ensure a sustainable modern workforce.
- More efficient training and data use – coordinated, evidence-led action avoids duplication and waste and adopts a values-based approach.
- Improved culture – staff feel valued, appreciated and most importantly safe.

The potential negative workforce implications when planning implementation and delivery of key actions aligning to the Plan include:

- Increased workload for small capacity teams such as the Public Health Team, Equality, Inclusion and Wellbeing Service, Learning and OD Service and Spiritual Care Service.
- Increased workload and ask of already pressured clinical areas within Women and Children and Mental Health.
- Increased potential for emotional burden for staff with lived experience of racism participating in engagement processes and the need for wraparound support.

Quality / Patient Care Implications
Positive implications for quality and patient care include:

- More equitable, person-centred care that recognises and addresses racial disparities and health inequalities in access and outcomes.
- Increased trust and engagement from minority ethnic communities, improving preventative and health-seeking behaviour and service uptake.
- Enhanced cultural competence among clinicians supporting Realistic Medicine principles.

Population Health & Care Strategy
The Anti-Racism Plan will directly support the delivery of the Population Health & Care Strategy by:

- Addressing structural inequities that underpin poorer outcomes for minority ethnic populations and easy-to-miss communities.
- Contributing to Realistic Medicine through person-centred care and reduction of unwarranted variation.

- Aligning with Value-Based Health & Care principles by improving outcomes for populations experiencing systemic disadvantage and reducing avoidable costs.

Climate Change / Sustainability Implications
While there are no direct climate change or sustainability implications at present, the Plan will support social sustainability by embedding equity and fairness within organisational culture and service delivery. Inclusive workplaces are more resilient and sustainable over time, which helps to strengthen community cohesion and adaptive capacity in response to climate and health emergencies.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

Whilst statutory engagement with stakeholders was not required, engagement was at the heart of the approach to developing the Anti-Racism Plan. There has been:
- Early engagement with key stakeholders including the Ethnic Diversity Network, Public Health colleagues, Trade Union partners, and clinical leaders.
- Input from patient representatives via initial engagement opportunities.
- Liaison with national NHS Scotland Equalities and Human Rights leads for alignment with national frameworks.

Going forward, planned communication and engagement will include:
- A communication campaign to launch our Anti-Racism Plan.
- Ongoing engagement sessions, listening events, and feedback loops to ensure co-production and transparency.
- Annual progress updates shared publicly and with community partners.

Full details can be viewed within appendix 5.

Appendices
Appendix 1 – Anti-Racism Plan
Appendix 2 – Scottish Government DL23 2024
Appendix 3 – EQIA
Appendix 4 – Delivery Tool
Appendix 5 – Communication and Launch Plan

Appendix 1

NHS Forth Valley

Anti-Racism Plan

From Acknowledgement to Action: Building an Anti-Racist NHS Forth Valley

Working Together For Change

Creating an anti-racist organisation is essential to safe, compassionate care - and it requires commitment from all of us. We ask our colleagues, patients, and communities to speak up, take action, and be part of the change.

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Joint Message from the Board Chair, Chief Executive and Ethnic Diversity Staff Network Chair

We openly acknowledge that racism impacts the people who use our services and our colleagues who work within NHS Forth Valley. Racism can be experienced through individual behaviours, organisational culture, health inequalities and the systems and structures that shape how decisions are made, and this is unacceptable. As an organisation and as NHS Forth Valley employees we have a responsibility to recognise this reality, challenge this reality it and actively change it.

Our Anti-Racism Plan sets out our commitment to take a clear and strong stance against racism. We will identify and challenge racism wherever it exists and takes practical, sustained actions to dismantle it within our organisation. Our aim is to provide a workplace where every member of staff feels valued, respected and safe at work – an environment where every individual can flourish.

We will create a culture where our colleagues feel confident and supported to report racism and discrimination. We will listen to those who experience racism, act on any concerns raised, and be open about what we are doing.

As a learning organisation, we must ensure we value, foster and celebrate diversity and inclusion within our organisation, appreciating the richness of skills and experiences that a diverse workforce brings.

We know that based on ethnicity, racialised health inequalities exist in people's access to and experience of services, leading to poorer health outcomes. We are committed to meeting the diverse needs of our communities, providing care and services that are inclusive and person-centred. Through our Population and Health Care Strategy a fundamental area of work is "Knowing our Population" which will enable us to understand and address the health inequalities which exist based on ethnicity within Forth Valley.

We will listen to our communities and use their lived experience to shape our services and reduce inequalities. As a Board, it is important that we are held accountable for progress, and we will work with our colleagues and communities as we take forward the implementation and delivery of our plan.

Creating an anti-racist NHS Forth Valley is not optional - it is essential to delivering safe, effective and compassionate care and ensuring that every member of our staff feels valued and supported. This will require courage, honesty and persistence at every level of the organisation. To drive meaningful change, we need your support and commitment to take action to make a difference.

Signatures To Be Added

Neena Mahal
Board Chair

Ross McGuffie
Chief Executive

Terence Savaridas
EDN Chair

Setting the Scene

As an organisation, we are clear: racism has no place in NHS Forth Valley. Yet we acknowledge that racial inequality continues to affect our services, our workforce, and the experiences of the communities we serve.

Scotland's demographic profile is changing and as an organisation we need to be agile, responsive and ready to adapt so that the care we deliver meets the demands of our increasingly diverse population.

To achieve real and meaningful change, we must do more than acknowledge these inequalities- we must actively address them. Developing an Anti-Racism Plan allows us to set out a clear and purposeful approach, outlining our ambitions and the actions we will take. This plan represents our commitment to move beyond words and towards deliberate, sustained action to challenge and dismantle racism wherever it occurs across our systems.

Racism is not limited to individual attitudes or behaviours - it is also embedded in long standing social and institutional patterns that can shape peoples experiences and opportunities. These patterns can create and sustain racial inequalities-but they can be changed and working toward that change is essential.

Health inequalities, driven by racism, continue to influence who becomes unwell, who receives timely and appropriate care, and who thrives. We know that colleagues from Black, Asian and minority ethnic backgrounds continue to encounter barriers to career progression, disproportionate higher levels of disciplinary action, and unacceptable experiences of discrimination.

We also know that some patients and communities report feeling unheard, disrespected, or treated inequitably. These experiences cause harm, erode trust, and undermine our ability to deliver compassionate, high-quality person-centred care.

As a nation we are also seeing a significant change in sentiment around both domestic and international policy. Within this context, the Scottish Government has directed all NHS Boards across Scotland to develop Anti-Racism Plans that are responsive to local needs whilst aligning with national priorities. You can read more about the background to the request in appendix 1.

Introduction: Why are we doing this?

Our Purpose

To achieve real, meaningful change to tackle racial inequalities, we recognise the need to create an impactful plan that details our approach and outlines our ambitions to drive meaningful change. Our Plan is our commitment to move beyond words and take deliberate, sustained action to challenge and dismantle racism wherever it occurs across our systems and our culture. Fairness, dignity and inclusion are core to our purpose as a public service. Racism in any form will not be tolerated –whether in systems or behaviours that exclude, or disadvantage people based on race, ethnicity or culture. Our ambition is clear:

To proactively identify and eliminate racism and discrimination in all its forms, creating environments that value and celebrate diversity.

To ensure equity of access, experience and outcomes, using evidence, data, and lived experience to shape sustainable change.

To create a workplace where all colleagues feel safe, valued and able to reach their full potential.

To build trust and stronger relationships with the diverse communities we serve, by listening and acting on lived experience.

Our Anti-Racism Plan demands accountability, transparency and collective leadership at all levels. Every Board member, every leader and every colleague has a responsibility to bring this to life, acting with integrity, challenging discrimination and living our values every day. The plan sets out not only what we will do, but how we will measure progress and hold ourselves to accountable to the highest standards.

Racism is not inevitable.It is a system that can - and must - be changed. Racism extends beyond individual prejudice to encompass deeply embedded structural, institutional, and historical power dynamics that create and sustain racial inequality. Together, we will create an NHS Forth Valley that truly reflects, represents and respects the people and communities it serves.

Introduction: Why are we doing this?

Alignment with Key Strategic Work

Our Plan directly supports and aligns with the following key pieces of strategic work across NHS Forth Valley.

- NHS Forth Valley Population Health and Care Strategy (2025 to 2035)
- Equality and Inclusion Strategic Framework (2025-2029)
- Culture Change and Compassionate Leadership Programme
- Workforce Wellbeing Framework (2025 to 2029)
- NHS Scotland Workforce Strategy
- Public Health Scotland's Ethnicity Data Improvement Programme
- NHS Forth Valley Values-Based Health and Care Strategy
- New Scots Integration Strategy

Together, these ensure that anti-racism is embedded across all aspects of strategic planning, leadership, and service delivery.

Vision and Objectives:
What do we want to achieve?

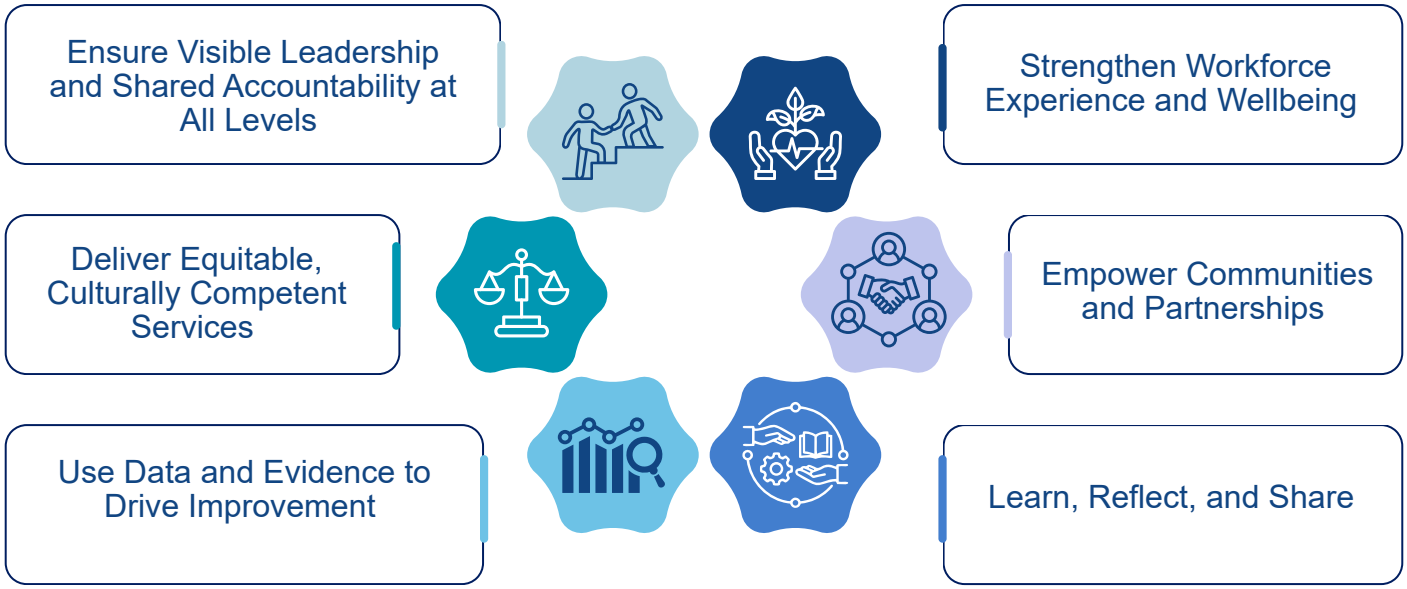
Our Anti-Racism Vision – Working Together for Change

We will create an anti-racist organisation where racism is actively challenged, diversity is valued, and every colleague, patient, and community member feels respected, safe, and heard.

Through commitment, accountability, and sustained action, we will reduce inequalities, improve experiences, and deliver equitable, compassionate care for all.

Key Aims and Objectives

In line with the Scottish Government's Anti-Racism in Health and Social Care Framework (appendix 1), NHS Forth Valley will focus improvements for Equity-Focused Service Delivery, Workforce, Leadership and Accountability, Data and Evidence and National Alignment, and Learning and Improvement. It is important that we outline what this means for us an organisation on a daily basis, beyond a list of actions, so have summarised below what this work will look and feel like.


Ensure Visible Leadership and Shared Accountability at All Levels
Strengthen Workforce Experience and Wellbeing
Deliver Equitable, Culturally Competent Services
Empower Communities and Partnerships
Use Data and Evidence to Drive Improvement
Learn, Reflect, and Share

Vision and Objectives:
What do we want to achieve?

1.Ensure Visible Leadership and Shared Accountability at All Levels

We will ensure that every colleague actively champions anti-racism and models inclusive behaviour that adheres to our shared values. Leadership will be driven by our Board-level Anti-Racism Senior Allyship role and through the Equality, Inclusion and Wellbeing Team and Staff Governance Committee. The Strategic Workforce Programme Board and the Staff Governance and Clinical Governance Committees are accountable for the oversight of our anti-racism progress as an organisation.

2.Strengthen Workforce Experience and Wellbeing

We will foster an inclusive and supportive working environment in which all colleagues feel safe to speak up, are empowered to thrive, and are able to progress equitably. Central to this commitment is our close partnership with the Ethnic Diversity Staff Network, whose insight and lived experience will be embedded into the design, delivery, and evaluation of our people practices and wellbeing initiatives. Together, we will promote Active Bystander and Unconscious Bias training, enhancing cultural competence, accountability, and inclusive leadership across the organisation. Our new Workforce Wellbeing Framework will further reinforce this approach by ensuring that culturally responsive and trauma-informed wellbeing support is accessible, relevant, and available when colleagues need it. By integrating lived experience, targeted training, and inclusive wellbeing provision, we will create a workplace culture in which diversity is valued, wellbeing is prioritised, and every colleague is supported to perform at their best.

3.Deliver Equitable, Culturally Competent Services

We will design and deliver services that recognise and respond to cultural and racial diversity by involving minority ethnic groups in the consultation and design stages of new services and in the redesign of existing services. We will take a whole-system approach that acknowledges that inequality is shaped by how services are accessed, delivered, and experienced, in addition to how they are designed. We will actively identify and remove structural, cultural, and practical barriers that disproportionately affect ethnic minority groups, such as language needs, digital exclusion and trust in our services.

Vision and Objectives:
What do we want to achieve?

4.Empower Communities and Partnerships

We will work alongside minority ethnic communities to hear and action vital lived experience input and feedback. As an Anchor institute, we will build upon our partnerships, with not just our local population, but our Colleges, Universities, Public and Third sector colleagues to work collaboratively to co-produce solutions that improve health outcomes and reduce inequalities. We will move beyond consultation to shared ownership and influence that creates inclusive and accessible mechanisms for feedback. We will commit to acting on what we hear, demonstrating how community insight leads to tangible change.

5.Use Data and Evidence to Drive Improvement

We will collect and analyse ethnicity data to identify inequalities, understand who is most affected and evaluate whether interventions are delivering meaningful change. Without robust and accurate ethnicity information, the experiences and outcomes of many people remain hidden within averages. This prevents us from fully recognising where inequities appear, which groups are disproportionately affected, and whether our interventions are making a real difference, both for our workforce and our communities. Our approach will focus on building trust, increasing transparency, and ensuring that data is used meaningfully to drive positive, anti-racist change rather than for compliance alone.

6.Learn, Reflect, and Share

We will deliver anti-racism learning across all levels of the organisation and share and learn from good practice nationally, building upon a culture of continuous learning at all levels. Our commitment includes celebrating the diversity, strengths and contributions of our people and communities. By valuing different cultural perspectives and lived experiences, we enrich the way we work together and deliver care.

Appendix two illustrates the initial key deliverables for each of the above aims and objectives for year one.

Providing Context

Racism, in any form, has no place in our organisation. However, robust national evidence and our own local insight, demonstrate that racism continues to affect colleagues, patients, and the communities we serve. These impacts are not always overt or intentional; they are often embedded within systems, processes, behaviours, and cultures that have evolved over time and can be overlooked. To build the culture of equity, inclusion, and compassion that NHS Forth Valley aspires to, we must be honest about how racism operates and deliberate in how we address it.

Racism manifests at multiple levels and in various ways. Institutional and systemic racism refers to the policies, practices, and organisational norms that - often unintentionally - create disadvantage for people from minority ethnic backgrounds. This can include inequities in recruitment, career progression, disciplinary processes, access to training, service design, and clinical outcomes. These patterns are sustained not by individual prejudice alone, but by systems that fail to account for structural inequality, historical disadvantage, and differing lived experiences. Recognising and addressing systemic racism requires us to examine data, challenge long-standing assumptions, and redesign systems so that equity is built in rather than added on.

Alongside this, interpersonal racism continues to affect the day-to-day experiences of colleagues and patients. This can include microaggressions, stereotyping, exclusion, discriminatory language or behaviour, and failures to appropriately challenge racism when it occurs. Even when subtle or unintended, these experiences accumulate over time, eroding trust, psychological safety, wellbeing, and a sense of belonging. Becoming an anti-racist organisation means creating an environment where racism is recognised, named, and actively challenged, and where colleagues feel safe and supported to speak up.
It is also essential to understand racism through the lens of intersectionality. People's experiences of racism are shaped by the interaction of ethnicity with other protected characteristics such as gender, disability, age, religion or belief, sexual orientation, and socio-economic status. For example, the experiences of a disabled Black colleague, or a Muslim woman, cannot be understood by looking at ethnicity alone. An intersectional approach enables us to better understand compounded disadvantage, tailor support appropriately, and avoid one-size-fits-all solutions.

This work aligns closely with our Culture Change and Compassionate Leadership Programme, which places kindness, accountability, and psychological safety at the centre of how we lead and work together. Becoming an anti-racist organisation is not solely about policies, frameworks, or compliance; it is about how decisions are made, how feedback is received, and how people are treated in moments that matter. It requires leaders and colleagues at all levels to reflect on our own role within systems, to listen actively to lived experience, and to be willing to challenge behaviours and practices that cause harm.

The following sections set out key definitions, explore how racism affects staff experience, patient outcomes, and organisational culture, and describe how we are learning from lived experience - particularly through partnership with our Ethnic Diversity Staff Network and community voices - to drive meaningful, sustained change. This is not a finite piece of work, but a long-term commitment to equity, accountability, and continuous improvement in how we care for one another and for the people we serve.

Key Definitions

To support a shared understanding, our plan uses the following key terms consistently. Clear definitions help ensure that when we talk about racism and anti-racism, we mean the same thing. We know that language in this area can evolve over time, and our understanding will continue to develop as we learn from staff, patients, and communities. These definitions are based on national guidance, Scottish Government terminology, and the work of other NHS Boards, but adapted to reflect NHS Forth Valley's values, culture and local context.

- **Racism** - Racism is when people are treated unfairly or less favourably because of their race, colour, nationality, or ethnic or cultural background. It can be individual (for example, personal prejudice or racist language) or structural (when policies, systems or practices disadvantage and /or harm certain groups, even if unintentionally).

- **Anti-Racism** - Anti-racism goes beyond simply not being racist. It is an active and ongoing commitment to recognise, challenge and change the systems, behaviours and attitudes that allow racism to exist. Anti-racism is a continuous process of learning, reflection and action at both individual and organisational levels.

- **Institutional Racism** - Institutional racism refers to the ways in which policies, practices and organisational culture can, often unintentionally, disadvantage and can harm people from minority ethnic backgrounds. It can appear in areas such as recruitment, career progression, decision-making, or access to services.

- **Micro-aggressions** - These are subtle, often unintentional comments or behaviours that communicate bias or negative assumptions about someone's race or background. While they may seem minor in isolation, repeated experiences can have a significant cumulative impact on wellbeing, confidence and belonging.

- **Intersectionality** - People's experiences are shaped by multiple parts of their identity, such as race, gender, disability, sexuality or religion. Intersectionality recognises that these factors overlap and interact, meaning that discrimination or disadvantage can be experienced in different and connected ways.

- **Positive Action** - The Equality Act 2010 allows organisations to take steps, known as positive action, to address disadvantage or under-representation of certain groups. This can include targeted development opportunities, outreach, or mentoring schemes aimed at achieving fairer representation.

The Impact of Racism on Staff

Racism has a negative impact on staff wellbeing, confidence and career progression. National workforce data and feedback from NHS staff surveys, including the recent BMA survey, show that colleagues from minority ethnic backgrounds are more likely to:

- experience bullying, harassment or discrimination at work.
- feel less confident in raising concerns.
- report fewer opportunities for training or promotion.
- experience barriers to progression into senior roles.

These experiences can lead to stress, reduced engagement, and feelings of isolation impacting both individuals and teams. They also undermine our shared values of compassion, dignity and respect.

Feedback from our Ethnic Diversity Network and staff engagement sessions reflects these themes locally, highlighting the importance of visible leadership, culturally competent wellbeing support and fair career development pathways.
Creating a fair and inclusive workplace is therefore not only a moral and legal responsibility, but also essential to delivering safe, effective and compassionate care.
Through our Culture Change and Compassionate Leadership Programme, we are – equipping leaders at every level to model inclusive behaviour, listen with empathy, and respond with honesty and accountability.

The Impact of Racism on Patients and Communities

Racism also affects the people who use our services. Evidence from Public Health Scotland and the Scottish Government shows that people from minority ethnic communities can face barriers when accessing healthcare and may experience poorer outcomes.

Nationally, racial inequalities persist in key areas such as maternity care, mental health, and long-term conditions like diabetes and cardiovascular disease.
Locally, NHS Forth Valley continues to act on these challenges through its ongoing equity-focused work and partnerships across public health, maternity and community wellbeing to address these disparities.

When people feel unwelcome, unheard or unsafe, they may delay seeking help or disengage from services.

Our Engagement Approach - Learning from Lived Experience

Data helps us understand what is happening; lived experience helps us understand why it is happening. This plan is shaped by conversations and engagement with:

- Staff networks particularly our Ethnic Diversity Network
- Local equality partners and community organisations.
- Regional and national learning through NHS Scotland equality networks.
- Colleagues participating in our Culture and Compassionate Leadership development sessions.

These conversations support honest listen, acknowledge discomfort, and strengthen trust and understanding across our organisation. They provide opportunities for collective reflection, helping both leaders and staff learn from one another's experiences to improve both workplace culture and patient care. We will continue to create psychologically safe spaces for these discussions, recognising that meaningful culture change requires consistent listening, learning and sustained action.

Insights from our Ethnic Diversity Network, staff wellbeing data and Culture Change discovery sessions will continue to inform and refine our anti-racism priorities. This ensures our plan remains responsive and evidence based and grounded in the experiences of our workforce and communities.

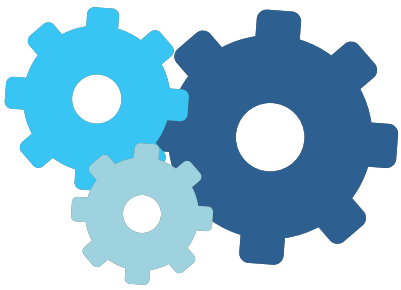
Our Approach:
How Will We Do This?

We have identified key actions under each of the above objectives. Together these are extensive and reflect the breadth and depth of the work that needs to be done. These actions are also specific and measurable. In appendix 2 we set these out as 'year 1 milestones'. The intention is that this will be a living document that evolves as progress is made, and new actions develop in response to our ongoing and open dialogue with our stakeholders.

Elements of these actions will contribute to improved individual and organisational outcomes, including increased confidence among staff and service users to report racism and discrimination, more consistent and effective responses to racist incidents, and greater trust in organisational processes and leadership.

This will support earlier intervention, better learning from incidents, and a more consistent application of an anti-racist approach across the organisation.
The Ethnic Diversity Staff Network will play a key supporting role by providing a safe and trusted space for colleagues to share lived experience, identify emerging issues, and inform organisational learning. The Network will act as a critical friend, offering insight on policy development, staff experience, and the effectiveness of reporting and response mechanisms. Where appropriate, it will also support awareness-raising, signposting, and dialogue, while remaining independent from formal complaint or investigation processes. This will help ensure that action taken is informed by lived experience, grounded in trust, and focused on continuous improvement.

A separate annual action and delivery tool will hold us to account, capturing the details of our progress and enabling us to identify and clearly set out the next set of actions and milestones that will lead us towards our objectives. A high-level snapshot of some of these actions are detailed below:



Equity-Focused Service Delivery

We will:

- Conduct Equality Impact Assessments (EQIAs) on all service redesigns to identify, prevent and mitigate any potential inequalities. Where issues or risks are identified, we will take clear and proportionate action to address them, including redesigning processes, removing barriers to access, and adapting services to better meet the diverse needs of our communities. Findings from EQIAs will directly inform decision-making, with actions tracked, reviewed, and held to account through appropriate governance arrangements.
- Co-design care pathways with minority ethnic communities through engagement sessions, patient panels, and targeted outreach activity. We will engage with colleagues, patients, communities and partners to ensure lived experience informs solutions and that improvements lead to measurable, sustained reductions in inequality.
- Improve access to interpreting and translation services across all clinical and non-clinical settings, ensuring that language is never a barrier to safe, effective and person-centred care.
- Strengthen ethnicity data capture and analysis to monitor patient access, experience, and outcomes, using this data to drive continuous improvement.
- Embed learning from local workstreams, including the Fair for All Group, the Perinatal Care Survey and the Maternity Voices Partnership, to ensure lived experience shapes service design and delivery.

Workforce

We will:

- Deliver anti-racism and cultural humility training for all staff, with enhanced sessions for leaders, building on the pilot of Active Bystander and Unconscious Bias training.
- Expand and strengthen the NHS Forth Valley Ethnic Diversity Staff Network providing protected time and resources to support participation and action planning.
- Review recruitment, promotion, and disciplinary processes through the Do No Harm project to eliminate bias and ensure equity at every stage.
- Provide safe, confidential reporting mechanisms and trauma-informed support for colleagues affected by racism ensuring consistent follow-up and psychological safety.
- Embed wellbeing and inclusion priorities through the Workforce Wellbeing Framework and the Culture Change and Compassionate Leadership Programme.

Leadership and Accountability

We will:

- Appoint a Senior Ally for Anti-Racism to provide visible leadership and advocacy at the highest level.
- Integrate anti-racism objectives within directorate performance reviews and individual appraisal processes ensuring that accountability is built into leadership practice.
- Include updates on anti-racism in quarterly Staff Governance and Clinical Governance Committee reports supporting transparent Board oversight.
- Promote leadership visibility, accountability and participation through active engagement in staff networks, equality events and community partnerships, reinforcing our commitment to role-modelling inclusive leadership.

Data and Evidence

We will:

- Increase the number of staff who feel confident and safe to share their equality information. We will clearly explain why we collect this data, how it will be used, and how it contributes to positive organisational change.
- Improve how we collect and analyse ethnicity data across key clinical pathways to support equitable access, experience and outcomes.
- Strengthen local recording and analysis through workforce systems such as eESS and JobTrain, in line with the national Ethnicity Data Improvement Programme.
- Use insights to identify patterns of under-representation, discrimination or disadvantage, supporting fair recruitment, progression and retention across our workforce.
- Publish annual workforce diversity and pay gap reports in line with our Public Sector Equality Duty (PSED) requirements to ensure transparency and accountability.
- Use qualitative evidence — including focus groups, surveys, and lived experience — alongside quantitative data to build a fuller understanding of staff and service user experiences.
- Share trends and learning across services and leadership teams to inform decision-making, service improvement and anti-racist practice.

National Alignment, Learning and Improvement

We will:

- Embed from national work led by the Equality and Human Rights Division, the NHS Scotland Race Equality Network, and the National NHS Ethnic Minority Forum
- Contribute to the NHS Scotland Anti-Racist Leadership Programme,
- Participate in the Health and Social Care Equality Improvement Collaborative, supporting consistent quality improvement on equality and human rights.
- Take insights and best practice from other NHS Boards and their Anti-Racism Plans, actions and evaluations
- Use evidence and learning from Public Health Scotland, NHS Education for Scotland, and the Scottish Social Services Council
- Engage with Scottish Government Fair Work, Workforce Equality, and Compassionate Leadership programmes, ensuring alignment with emerging priorities and guidance
- Share learning through the Equality and Human Rights Leads Network and the NHS Scotland Race Equality Network, ensuring that local practice is informed by national experience.
- Learn from other NHS Boards and their Anti-Racism Plans and approaches as we recognise that genuine progress towards an anti-racist NHS can only be achieved through shared learning, collaboration and transparency across the whole system.

Our Governance: How Will We Know We're Making a Difference?

Ultimately, whilst we will endeavour to collect data and evidence to allow for an assessment of our progress, the proof will be in the voices, experiences and feedback of our minority ethnic colleagues and service users.

Our commitment to anti-racism will be sustained through clear governance, visible leadership and transparent reporting. Our Plan will be overseen by a dedicated working group of key stakeholders that report into the Strategic Workforce Programme Board and then to the Staff Governance and Clinical Governance Committees. Progress will also be shared through our annual Equality Outcomes Report and regular updates to staff networks and local communities, ensuring accountability and visibility across the organisation. Our Board have a legal responsibility to monitor progress and through the above governance routes, will ensure transparency and accountability for the successful implementation of our Anti-Racism Plan.

Monitoring and Evaluation

To ensure our actions lead to meaningful change, progress will be monitored, evaluated and reviewed regularly. We will:

- Develop measurable indicators aligned to the Scottish Government's equality outcomes and national reporting requirements, ensuring input from the user population in their implementation.
- Use workforce and service data to track trends, identify disparities and evaluate the impact of our actions and ensure continuity based on evidence from process audit trails.
- Collect qualitative feedback from staff, patients and communities to understand lived experience and monitor cultural change and integrate anti-racism actions within existing governance frameworks.
- Publish updates and key learning annually through internal and public equality reports, ensuring transparency through the publication of actionable plans and what outcomes have been delivered.

Evaluation will focus on both outcomes (what has changed) and process (how we are achieving change). This will ensure that progress is evidence-based, transparent and accountable at every level.

Continuing Engagement and Updates

Sustained progress relies on ongoing dialogue with colleagues, patients and partners. We will continue to:

- Engage with staff networks, community organisations and equality partners to gather feedback share experiences and understand emerging issues.
- Share progress through regular updates, internal communications and events.
- Ensure colleagues understand how their feedback informs action and decision-making; and
- Adapt our approach based on what we learn, recognising that anti-racism is a continual process of listening, reflection and improvement.

Summary:
Looking Ahead

We are committed to creating the conditions for an anti-racist NHS Forth Valley. We will share our progress, our challenges and examples of what is working well. By being clear about the actions we take and how we measure their impact, we will ensure our Plan remains focused on improvement rather than intention alone.

Our work will reflect national priorities while also responding to the needs of our workforce and communities to ensure our Anti-Racism Plan remains aligned, evidence-informed and impactful. We know that reliable, transparent data is essential to understanding where racial inequalities exist and how to address them effectively and we are committed to improving the quality, completeness and use of ethnicity data across both our workforce and service user records.

Our aim is to embed anti-racism as a core part of how NHS Forth Valley works. This is not a one-off project, but a lasting commitment that shapes our culture, policies and everyday practice.

Our Anti-Racism Plan marks an important step in our ongoing journey to become a fairer, more compassionate and inclusive organisation.
Real progress will depend on continuous listening, learning and partnership across our staff, our services, and our communities.
By working together, holding ourselves accountable and living our shared values every day, NHS Forth Valley will continue to build a culture where everyone feels respected, valued and able to thrive.

Summary:
Looking Ahead

Get Involved

Creating an anti-racist organisation is a shared responsibility, and meaningful change depends on the involvement of our colleagues, patients, and communities.

There are many ways to get involved - by sharing lived experiences, speaking up about racism and discrimination, taking part in learning and engagement opportunities, and helping shape how our services are designed and delivered.

By working together, listening openly, and taking action, we can make a lasting difference.

To find out more, please get in touch via FV.equality@nhs.scot.

Alternative Formats

We want you to be able to access this document in the way that best suits you. To request this document be made available in another format, please contact:

Phone: 01324 590886

Text: 07990 690605

Email: FV.interpretation@nhs.scot

Appendix 1:
Scottish Government DL

The Scottish Government issued a DL to every NHS Board to develop an Anti-Racism Plan that sets out how they will contribute to eliminating racism across Scotland's health and care system. Figure 1 illustrates the detail of the Scottish Government ask, with a dual focus on both workforce (including culture and wellbeing) and equity-focused service delivery, for which there are three key areas:

1. Type 2 Diabetes and Cardiovascular Disease prevention
2. Perinatal Care
3. Mental Health

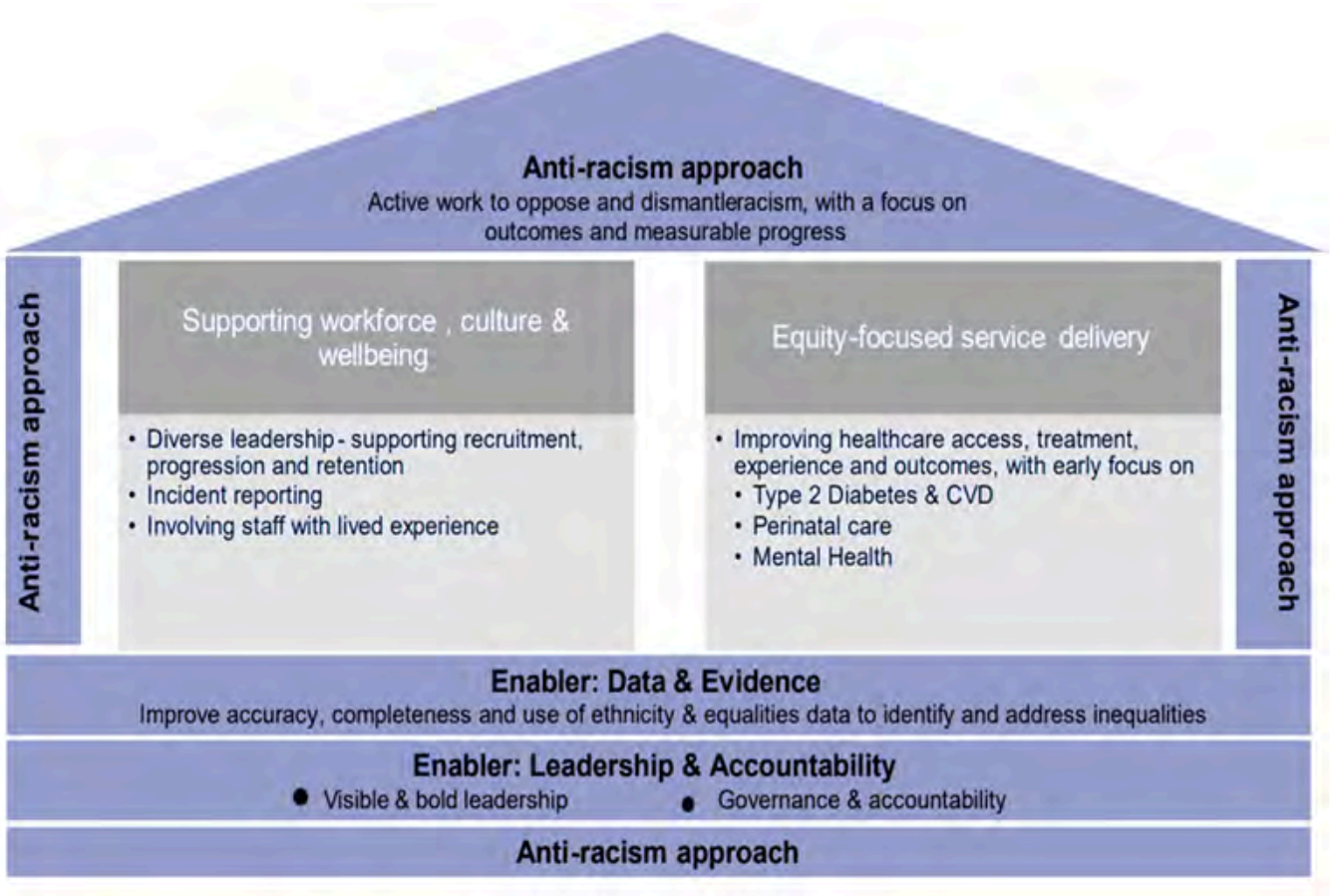

Anti-racism approach
Active work to oppose and dismantleracism, with a focus on outcomes and measurable progress
Anti-racism approach
Supporting workforce , culture & wellbeing
• Diverse leadership - supporting recruitment, progression and retention
• Incident reporting
• Involving staff with lived experience
Equity-focused service delivery
• Improving healthcare access, treatment, experience and outcomes, with early focus on
• Type 2 Diabetes & CVD
• Perinatal care
• Mental Health
Anti-racism approach
Enabler: Data & Evidence
Improve accuracy, completeness and use of ethnicity & equalities data to identify and address inequalities
Enabler: Leadership & Accountability
Visible & bold leadership
Governance & accountability
Anti-racism approach

Figure 1 above details the two key enablers of leadership and accountability and data and evidence. For NHS Forth Valley, our Plan provides the structure for local action to address racial inequality in both workforce experience and service delivery. It aligns with our Board's purpose and our agreed vision for our Population Health and Care Strategy which is to improve the health and wellbeing of everyone living in Forth Valley by working with our partners to prevent people from becoming unwell, reduce health inequalities and make the best use of the resources available to achieve better outcomes.

Appendix 2: Year One Key Deliverables

1. Equity-Focused Delivery

Deliver Equitable, Culturally Competent Services

We said we would: Ensure services are designed and delivered in ways that respond to racial and cultural diversity. This will include an initial focus on diabetes and cardiovascular health, Perinatal and maternity care and mental health, as outlined by Scottish Government as key focus areas in response to evidence.

Priority Actions	Milestones (Year 1)	Success Measures
Continue to encourage better completion rates and effective use of EQIAs	Ongoing improvement work for EQIAs to reduce administrative element and focus on key discussions and mitigations against potential discriminatory practice.	Increase in number of completed EQIAs and better lived experience engagement and co-production as evidenced via Pentana. Clear evidence of how EQIAs have been used to inform better decision making and reduce inequalities.
Strengthen workforce skills in cultural competence	Encourage uptake of TURAS modules and offers of support from Equality, Inclusion and Wellbeing Service by improving training and awareness sessions offered and increased capacity to deliver these to reach more colleagues.	Increase in uptake of training and sessions as evidenced via Pentana and TURAS records. Staff report feeling more confident and knowledgeable about racism and health inequalities. Patient data and feedback highlight better access to services and less incidents of racism.
Review current patient and service-user feedback to identify areas for improvement in relation to anti-racism.	Responsive to feedback and evidence of positive changes made as a result of listening to lived experience input.	Patient-reported experience improvements and feedback from key third sector organisations in relation to lived experience and community insights including barriers or gaps in services and opportunities for positive impact. Greater collaboration and increased engagement.
Collaborate with communities for any service redesign.	Links with actions above, but co-production workshops with diverse community groups such as focus groups or surveys.	Greater trust evidenced in feedback from minority ethnic patients, which includes an increase in engagement numbers.
Specific focus on diabetes, perinatal care and maternity and mental health for targeted outreach, feedback and support.	Review of current gaps and barriers to access and effective care. Increased awareness for patients around the support available to them and how to provide feedback (actively supported with simple tools and mechanisms that encourage feedback). Increased education for colleagues around cultural sensitivities that may contribute to health inequalities within this area.	Increase in feedback from minority ethnic patients in this area, increase in staff accessing education resources and evidence from targeted outreach that illustrates widening reach and access. Area-specific feedback and data.

Appendix 2:
Year One Key Deliverables

2.Workforce

Support Workforce Experience and Wellbeing

We said we would: Ensure every colleague feels safe, valued, and able to progress equitably.

Priority Actions	Milestones (Year 1)	Success Measures
Strengthen voice and lived experience structures	Continue to build upon success of Ethnic Diversity Network and grow membership.	Increased participation in employee networks and opportunities for lived experience voices alongside engagement and support from allies.
Enable safe reporting and psychological safety	Link with ongoing Culture Change and Compassionate Leadership Programme work around Psychological Safety and create additional protected characteristics questionnaire for IR1s relating to discrimination to allow better understanding and targeted support and learning.	Reduced perceived barriers to reporting which will likely result in an initial increase in reporting data. Improved protected characteristics data and targeted interventions and learning.
Improve cultural capability and challenge harmful behaviours	Rollout Active Bystander & Unconscious Bias training and encourage uptake of mandatory TURAS EDI training in addition to the other modules available that enhance cultural understanding and knowledge.	Increase in engagement and number of colleagues undertaking training, meeting targets for mandatory EDI training module and showing an increase in access for additional modules and resources.
Embed culturally responsive wellbeing support	Co-develop wellbeing resources with minority ethnic colleagues as part of wider Workforce Wellbeing Framework.	Increased uptake of support services by minority ethnic colleagues.

Appendix 2:
Year One Key Deliverables

3. Leadership and Accountability

Show Leadership and Accountability at All Levels

We said we would: Ensure leadership actively champions anti-racism and models inclusive behaviours. Build mechanisms that hold the organisation accountable for progress.

Priority Actions	Milestones (Year 1)	Success Measures
Clarify Board-level roles and responsibilities for anti-racism	Agree remit for Board-level Anti-Racism Senior Ally; finalise and share governance route with key dates.	Allyship responsibilities public and visible; leadership attendance at Ethnic Diversity Network and community events/opportunities for hearing lived experience input and feedback. Link to Board objectives.
Embed oversight within governance structures	Integrate Pentana dashboards & updates into Staff Governance Committee agenda as part of wider Equality, Inclusion and Wellbeing Service improvement work.	Creation of dashboard and improved feedback from governance checkpoints.
Develop leadership capability and anti-racism expectations	Embed anti-racism Plan into key strategic priorities of our leaders, linking with the new Leadership and Management Framework to ensure inclusive leadership standards, aligned to organisational values.	Data from Leadership and Management Framework illustrating engagement. iMatter data – improved around leadership.
Create transparent progress reporting	Publish first annual summary of Anti-Racism Plan delivery in April 2027 to show progress one year on (links to annual Equality Outcomes progress report published each April).	Improved confidence in leadership from workforce survey data (iMatter) and improved feedback and compliments/reduction in complaints. Qualitative feedback from minority ethnic community members.

Appendix 2:
Year One Key Deliverables

NHS Forth Valley

4. Data and Evidence

Use Insights for Improvement and Empower Communities and Partnerships

We said we would: Improve visibility of ethnicity disparities and track meaningful change, building trust and co-producing solutions with minority ethnic communities.

Priority Actions	Milestones (Year 1)	Success Measures
Enhance accuracy and completeness of ethnicity data	Data quality audit and improvement approach agreed.	Increased engagement in data i.e. eESS ethnicity data.
Develop routine ethnicity-based insights	Creation of Pentana performance dashboard.	Inequalities visibly tracked and monitored.
Use data to drive targeted interventions	Pilot improvement action in one workforce and one service area based on Pentana dashboard data.	Evidence of reduction in identified inequalities.
Map key community partners and establish shared goals	Have increased engagement and key contacts for third sector groups.	Increased joint initiatives and shared learning.
Strengthen collaborative action with Anchor institutions	Widen out local Anti-Racism Plan working group to engage with Anchor colleagues, where appropriate, for joint working.	Development of collaborative approach, actions and resources.
Create accessible feedback mechanisms	Liaise with local groups to improve our feedback channels, removing barriers and encouraging engagement based on lived experience feedback.	Growth in feedback from underrepresented groups.

Appendix 2:
Year One Key Deliverables

5. National Alignment, Learning and Improvement

Learn, Reflect and Share

We said we would: Build a culture of continuous learning and celebration of racial and cultural diversity.

Priority Actions	Milestones (Year 1)	Success Measures
Share local and national best practice	Create internal anti-racism knowledge hub within MS Teams channel and Staffnet.	Uptake of resources across teams
Celebrate contributions and cultural diversity	Annual calendar of cultural recognition events co-designed with colleagues.	Workforce survey (iMatter etc.) shows improved sense of belonging and feeling valued.
Establish continuous improvement feedback cycle	Work with Ethnic Diversity Network colleagues to review progress to data and identify key deliverables for future improvements.	Actionable priorities set for Year 2 onwards.
Make key links and contacts with Local Authority, HSCP, Serco and Trade Union colleagues who are leading on this area to share learning and align approach.	Liaise and collaborate with HSCP, Council, Serco and Trade Union equality champions/leads for shared learning to apply an integrated approach.	Evidence of joint-working and collaborative approaches.

NHS Forth Valley

01324 590886

FV.equality@nhs.scot

Equality, Inclusion and Wellbeing Service,
Forth Valley Sensory Centre

https://nhsforthvalley.com

The Scottish Government

Health Workforce Directorate and
Directorate for Population Health

E: lcw@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

Appendix 2

Dear Colleagues,

ANTI-RACISM PLANS - GUIDANCE

Background

1. In recognising that racism is a public health issue across Scotland, we are asking our Health Boards to make more rapid progress in tackling the impacts of racism on colleagues, service users and on health outcomes.

2. Fiona Hogg wrote to Chief Executives, Board Chairs and HR Directors in March 2024, setting out an additional requirement to embed anti-racism within Executive objectives for 2024/25. Each individual set of Executive objectives should include a commitment that the Board will develop, if not already in place, and deliver against their own anti-racism plan, covering both workforce and racialised healthcare inequalities. The letter stated that guidance would follow to support this work.

3. This letter includes the guidance document intended to support the development of NHS Scotland Board anti-racism plans. Please see the Annex for the full guidance document.

4. The guidance has been developed at a national level to support the ethos of a 'Once for Scotland' approach, while leaving adequate scope for Boards to take ownership of plans, and to identify additional local priorities for action.

Action

5. Executives should:
   a. Note this guidance and refer to it during the development, delivery and review of their Board anti-racism plan.

DL23 (2024)

9 September 2024

Addressees

For action
NHS Board Chief Executives,
NHS Board Chairs,
NHS Board HR Directors,
Directors of Public Health

For information
Employee Directors

Enquiries to:

Leadership, Culture & Wellbeing Division

E: lcw@gov.scot

b. Share this guidance with their teams and stakeholders involved in the development, delivery and review of anti-racism plans.

c. Ensure that plans are developed in partnership with colleagues, staffside, management as well as forums and organisations representing minority ethnic colleagues and communities, and these groups have a role in the delivery and review of progress with the plans.

d. As appropriate, ensure alignment with national areas of focus (the Scottish Government framework for action), as set out in the guidance.

6. Boards should report on the progress with developing and delivering against their anti-racism plan, via the Quarterly Annual Delivery Plan (ADP) reporting in Q2 and Q4 2024/ 2025. Further advice will be provided as part of the ADP process, but this reporting should include:
    a. Information about local governance and scrutiny of anti-racism plans.
    b. Reporting on the key priorities identified by the Board, and how the plan aligns with the Scottish Government framework for action.
    c. Key milestones and progress made on development/delivery.
    d. Information on the approach to developing the plan in partnership with minority ethnic colleagues, forums and stakeholders.

7. Board Remuneration Committees will be expected to receive assurance, through their oversight of executive objectives and performance review, to satisfy themselves that the anti-racism objective has been appropriately set and that progress is made in the mid-year and end-of-year review process. This will also be picked up in the end of year oversight by the National Performance Management Committee (NPMC).

8. Boards should work in partnership with local colleague diversity and race networks to ensure they are delivering on the needs of colleagues for an improved working environment as well as a focus on equity-focused service delivery for the communities they serve. Whilst some key actions and improvements will be part of the Board anti-racism plan, there is a wider requirement for Boards to ensure this in embedded in all areas of work.

9. Boards are also encouraged to work with national forums and networks, such as the NHS Ethnic Minority Forum (EMF), ensuring their Board is represented on these groups and that there is good flow of information into and out of these forums. As part of a standing agenda, the EMF members will be encouraged to regularly share their Board progress, initiatives and any challenges or concerns to support knowledge-sharing and best practice across our system.

10. Whilst this work will be a collaborative effort across the Executive team, it would be helpful for Boards to have a nominated Executive lead for this work. The role of an Executive lead would involve being a point of contact for updates and resources, as well as escalation or queries, if required. Please confirm the contact point for your board, by sending details to leadershipandtalentmanagement@gov.scot.

We appreciate the support and commitment of leaders and colleagues across NHS Scotland in delivering on this important commitment to tackle racism and reduce health inequalities.

Yours faithfully

Gillian Russell
Director of Health Workforce

Richard Foggo
Director of Population Health

ANNEX

NHS Board Anti-racism plans - Guidance

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1. Acknowledgements

We would like to thank the following for their support in developing this guidance:

- The NHS Ethnic Minority Forum
- Public Health Scotland
- NHS Education for Scotland
- Healthcare Improvement Scotland
- NHS Grampian
- NHS Lothian
- NHS Borders
- Scottish Workforce and Staff Governance Forum (SWAG)

2. Introduction

[3 min read] This section will provide you with a very brief introduction to racialised health inequalities, our approach to language, the scope of this work and how you might wish to use this guide.

Health inequalities disproportionately affect marginalised groups. This is because poverty and wider economic inequalities interact with other forms of inequality, disadvantage and discrimination, creating particular barriers for certain groups.

Covid-19 shone a light on the fact that people from a number of minority ethnic groups experienced stark inequalities in health outcomes, as well as inequalities in access to and experience of health services compared to majority White groups. This applied to health and social care staff as well as patients.

Most minority ethnic groups are disproportionately affected by socio-economic inequality. This is because structural racism contributes to and creates additional barriers, challenges and unequal treatment across wider determinants of health, for example employment and housing. This further impacts negatively on health.

Reducing health inequalities, improving population health and creating a more sustainable health and care system are top priorities for the Scottish Government. Dismantling systemic racism in Scotland is an integral part of this ambition. It has to be, because racism is increasingly recognised as a driver of inequalities for staff as well as patients, a public health challenge and a barrier to appropriate healthcare.

In order to achieve health equity, Professor Sir Michael Marmot has said that we must tackle racism, discrimination and their consequences. This is why we are now asking Boards to develop anti-racism plans.

2.1 Our approach to language

We recognise that across Scotland, people belonging to minority ethnic communities define themselves and their communities in different ways. As a result, it is unlikely that any single term will be suitable for all communities. Whenever possible, we will avoid using collective terms and composite categories that group various minority ethnic communities together, as this can overlook the unique identities and specific inequalities and needs of each group. We will always endeavour to be as specific as possible. We will also encourage the communities we work with to use their preferred language and we will adopt this language wherever possible in our communications.

As our understanding of race, ethnicity and racism grows, the Scottish Government (and others) are increasingly using terms such as ‘adversely racialised’, ‘racially minoritised’, ‘racialised minorities’, and ‘racialisation’. The change in language recognises that racism is a systemic problem where systems and structures unequally advantage or disadvantage people and communities based on their perceived ‘race’. The term ‘racialisation’ highlights the process by which people are categorised based on their ‘race’, with each category occupying a different position in the social hierarchy. The term ‘minoritised’ reflects that a group/community that is treated as a minority, often in unfair ways, even though they may

not be a statistical minority in the global population. We use these terms interchangeably with the term 'minority ethnic group', depending on the context.

We will remain adaptable and refine our approach to language as our and society's understanding of race, ethnicity, racism, and health continues to develop. We welcome constructive challenge and feedback on our language and our wider work to address racialised healthcare inequalities through an anti-racism approach.

See Annex 4 for further information, including a list of terms and abbreviations used.

2.2 Scope

For the purposes of this work, our focus is on people who experience racialised healthcare inequalities, including Black, Asian and minority White groups such as Gypsy Travellers.

Current focus areas included in the Framework for Action are based on the recommendations of the Expert Reference Group on Covid-19 and Ethnicity (ERG), the health goals in the Race Equality Framework for Scotland 2016-2030 (REF) and wider evidence of where improvement is needed across health and care workforce and population level access and outcomes.

2.3 Using this guide

This guide has been developed to support a structured approach to local planning and improvement through an anti-racism lens. You can use it:

- As a starting point, e.g. if you are developing/ refining your anti-racism plan;
- To enable alignment to national and strategic priorities;
- To access useful resources quickly and easily.

We recognise that each Board will be at a different stage of their anti-racism journey. We also recognise that delivering against our ambitions to improve population health and narrowing inequalities in the current financial environment is challenging.

The guidance is a living document and will be refreshed regularly. We welcome feedback on this guide especially what Boards have found most – or least – helpful, and what could be improved. Please also get in touch via HealthEquity@gov.scot if you have local examples of good or emerging practice which we can reflect in the next iteration.

3. Executive summary

Background

Racism is a significant public health challenge and the NHS has a key role to play in tackling racism, reducing racialised health inequalities and creating a more equitable health and care system for all. Health Boards have been asked to develop and deliver against their own anti-racism plans, covering both workforce and equity-focused service delivery. Section 4 (Background) and Annex 1 (Key evidence) of the guidance set the stage for understanding racialised health inequalities, and why an anti-racism focus is needed in NHS Scotland.

Anti-racism approaches have been recognised as an integral improvement tool to help advance equality within the workforce and for patients / service users. As such, a focus on anti-racism has wider applicability and will generate learning to support improvements that benefits everyone, regardless of protected characteristic. This guidance contains and signposts to helpful tools and resources for creating an anti-racist and more equitable healthcare system for everyone.

The guidance is a living document and will be refreshed regularly. We welcome feedback, especially relating to what Boards have found most – or least – useful, what is missing, and what could be improved. Please contact HealthEquity@gov.scot with your feedback, comments or questions.

Developing your anti-racism plan

Actions and plans designed from an anti-racism perspective should be clear about the change, outcome and impact to be achieved in the lives of minority ethnic communities.

A strong anti-racism plan should include a mission and vision; a plan to engage and empower people with experience of racism and discrimination; strategic outcomes that are specific about the impact/change to be achieved; and actions, deliverables and indicators for each strategic outcome.

Suggested steps for developing your plan include:

- Establishing leadership and governance arrangements that provide visibility at Board level;
- An evidence-based approach, drawing on Annex 1, alongside local qualitative and quantitative data and insights;
- Active and respectful involvement of minority ethnic workforce and patients in the planning process, including in identifying immediate challenges and priorities for improvement;
- Agreeing strategic priorities, outcomes, progress indicators and accountability mechanisms in collaboration with minority ethnic staff and communities.

When working with minority ethnic staff and communities, for example in identifying immediate challenges and priorities for improvement, it is vital to consider intersectionality. By this we mean seeking to understand how experiences of disadvantage within already marginalised groups (e.g. minority ethnic women) compound and differ. This will help you identify and address structural barriers you may not have previously considered.

Framework for Action

The framework for action sets out current areas of focus based on Expert Reference Group on Covid-19 and Ethnicity (ERG) recommendations and existing evidence of racialised healthcare inequalities in perinatal care. The framework is designed to support alignment of national and local action, as well as guide Board prioritisation and planning in tackling racialised healthcare inequalities through an anti-racism approach. Anti-racism focuses on proactive, concrete action that challenges and dismantles racism, whatever form it takes.

The framework has a **twin focus on workforce and service delivery**:

- Under workforce, culture & wellbeing, there are three specific areas of focus: diverse leadership (recruitment, progression and retention), incident reporting and involving staff with lived experience.
- Under equity-focused service delivery, there are three specific areas of focus: Type 2 Diabetes (T2D) and Cardio-Vascular Disease (CVD) prevention, perinatal care and mental health (specifically quality of care and treatment, and services that provide support to people in distress/crisis).

The framework and guidance also highlights the importance of a specific focus on two key enablers:

- Leadership & Accountability: Strong leadership on anti-racism is crucial, and includes taking steps to name racism, taking steps to understand how it operates, and taking action, including strengthening governance and accountability mechanisms on anti-racism.
- Data and evidence: Robust data are critical to monitoring equity of access and outcomes, and measuring progress. As such, recommended actions include improving levels of completeness and accuracy of data, and building understanding/confidence of equalities data collection and use.

Conclusion

Developing and implementing anti-racism plans will help address racialised health inequalities and contribute to broader improvement goals across NHS Scotland. Racism is a significant public health challenge and the NHS has a key role to play in tackling racism, reducing racialised health inequalities and creating a more equitable health and care system for all.

4. Background

[5 min read] This section covers:
- The ask of NHS Board Executives, Chairs and HR Directors;
- How NHS Boards can benefit from developing and delivering on anti-racism plans;
- Why an anti-racism focus is needed in NHS Scotland.

Fiona Hogg, Chief People Officer, wrote to NHS Board Chief Executives, NHS Board Chairs, and NHS Board HR Directors on 11 March about 2024/25 Objective Setting for Executives within NHS Scotland. The letter set out the details of an additional requirement within Executive objectives for the 2024/25 reporting year to "develop (if not already in place) and deliver against their own anti-racism plan, which covers both workforce and racialised healthcare inequalities".

The letter also indicated that Board Anti-Racism Plans should be developed with stakeholders, including forums representing minority ethnic colleagues and communities themselves, and that progress should be discussed and scrutinised at relevant forums and committees.

4.1 Benefits of developing, and delivering on, your anti-racism plan

- Anti-racism planning will support Boards in developing and embedding an anti-racism approach into existing work;
- Anti-racism approaches have been recognised as an integral improvement tool to help advance equality within the workforce and for patients / service users;
- Anti-racism principles also have wider applicability and will support improvement work relating to delivery of equitable healthcare, ultimately benefitting everyone, regardless of protected characteristics;
- As such, your anti-racism plan can contribute to:

    - Meeting your legal obligations under the Equality Act 2010 and Public Sector Equality duties, including equality outcomes and reporting (see below section for more information);
    - Effective delivery of NHS Scotland 2024/25 planning priority to tackle racialised health inequalities;
    - Delivery of Principles for Safe and Effective Recovery as set in the NHS Recovery Plan 2021-2026;
    - Dismantling of structural racism;
    - Generating learning that can be applied to dismantle other forms of discrimination;
    - Your role as an Anchor institution in addressing the drivers behind health inequalities within your community and workforce.

4.2 Why does NHS Scotland need an anti-racism focus?

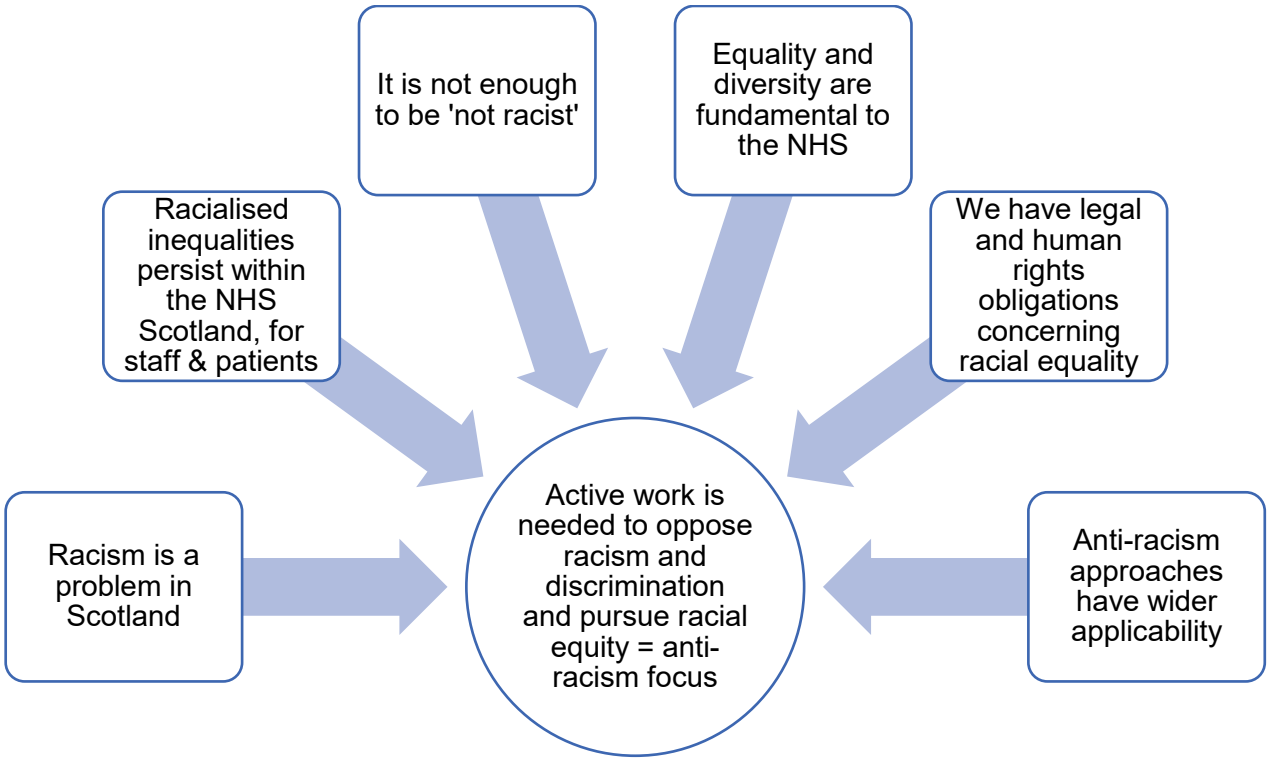

It is not enough to be 'not racist'
Equality and diversity are fundamental to the NHS
Racialised inequalities persist within the NHS Scotland, for staff & patients
We have legal and human rights obligations concerning racial equality
Racism is a problem in Scotland
Active work is needed to oppose racism and discrimination and pursue racial equity = anti-racism focus
Anti-racism approaches have wider applicability

Figure 1: Why does NHS Scotland need an anti-racism focus?

Racism is a problem in Scotland.

Evidence and experience tell us that racism is a problem in Scotland. The racialised inequalities we live with today are deeply embedded into our structures, institutions and systems. This means that, at the time when our current systems and institutions were designed, they were done so without consideration for racial diversity or equality.

A substantial and ever growing body of evidence show that structural racism drives health inequalities for adversely racialised communities. Racism impacts health directly, for example through increased stress, poor mental health and cardiovascular disease. Racism also impacts health indirectly. For example, through disadvantaged access to physical, economic and social resources and socio-economic inequalities. It also translates into poor experiences in organisational and service settings. See Annex 1 for evidence and Annex 5 for actionable insights, information and resources.

Racialised inequalities persist in healthcare.

Some people in Scotland are less well served and supported by the health and care system as a consequence of their race and ethnicity. For example, in October 2023, several media outlets in Scotland reported on the increase of racist incidents in NHS Scotland. A recent study also found that the receipt of routine diabetes care is lower in minority ethnic compared to majority White groups, in both the short- and medium-term following diabetes.

It is therefore vital that we build equity and anti-racism approaches into all we do as we recover from the pandemic.

It is not enough to be 'not racist'. We must be proactively anti-racism.

In 2020, Scottish Parliament acknowledged that Scotland has a problem of structural racism, and that it is not enough to be 'not racist'. The Parliamentary debate 'Showing Solidarity with Anti-racism' showed there is cross-Party support for tackling structural racism and advancing race equality. Since then, Scotland's Anti-racist employment strategy (2022), Anti-racism in Education Programme (AREP), the Scottish Association of Social Work(SASW) Anti-racism Action Plan (2022), the Anti-racism in Scotland Progress review (2023), and the Chief Constable statement on institutional discrimination (2023) contain explicit anti-racism statements and action.

The Anti-Racism in Scotland Progress Review provides an overview of Scottish Government commitments within the Race Equality Framework (2016-2030), including the four public health related goals (two related to population level health outcomes and access; and two related to Scotland's health and care workforce):

- Goal 26: Minority ethnic communities and individuals experience better health and wellbeing outcomes;
- Goal 27: Minority ethnic communities and individuals experience improved access to health and social care services at a local and national level to support their needs;
- Goal 28: Scotland's health and social care workers are better able to tackle racism and promote equality and community cohesion in delivery of health and social care services;
- Goal 29: Scotland's health and social care workforce better reflects the diversity of its communities.

A 2021 review carried out by the Coalition for Racial Equality and Rights (CRER) demonstrated that "over the past twenty years the same themes and priorities were present across the national strategies. Despite this, progress has been limited. We therefore need an explicit and sustained focus on anti-racism and racialised health inequalities. By anti-racism, we mean active work to oppose racism and to pursue racial equity, so that someone's racial identity is no longer a factor in determining how they fare in life.

We have legal and human rights obligations to monitor and improve the experience of staff and patients with protected characteristics.

Race discrimination, or unfairly disadvantaging someone for reasons related to their race, has been illegal in the UK since 1976. The Equality Act 2010 definition of race includes colour, nationality, ethnic and national origins. Chiefly, the Public Sector Equality Duty (PSED) (Section 149 of the Equality Act 2010) requires all public bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010;
- advance equality of opportunity between people who share a relevant protected characteristic and those who do not;
- foster good relations between people who share and people who share a relevant protected characteristic and those who do not.

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 requires listed authorities to publish a set of equality outcomes to establish a clear link between evidence

and action taken to advance equality, improve decision-making, accountability and tangible change for communities and staff.

Equality and diversity are fundamental principles of the NHS.

Since its inception in 1948, the NHS has provided free health care at the point of use. Shortly after, in 1949, saw the first international recruitment drive to recruit staff from the West Indies to the NHS.

We know that NHS Scotland still has a strong commitment to equality, diversity and inclusion across their workforce and service delivery, including a specific objective for Board Chairs in this area, and that there is excellent work already underway to drive forward improvements. However, in spite of existing commitment and a strong legal framework through the Equality Act 2010 and Public Sector Equality Duty, progress to reduce racialised inequalities in healthcare and workforce has unfortunately been limited. That is why a different approach is needed.

Anti-racism principles and practice have wider applicability to all protected characteristics and marginalised groups.

Anti-racism approaches have been recognised as an integral improvement tool to help advance equality within the workforce and for patients / service users. Anti-racism approaches have the potential to create strong foundations and learning that can be applied to tackle other forms of inequity and structural discrimination.

5. Developing your anti-racism plan

[5 min read] After reading this section you will have a clear idea of:
- What a strong anti-racism plan might contain;
- The steps take in developing your plan and useful resources to support the process.

Actions and plans designed from an anti-racism perspective should be clear about the change, outcome and impact to be achieved in the lives of minority ethnic communities.

"Only outcomes, not intent, demonstrate whether actions and policies are racist." (Wellcomes-Anti-racist-principles-and-toolkit-2021.pdf)

5.1 What would a strong anti-racism plan look like?

A strong anti-racism plan is likely to include the following:

A mission and vision, capable of reaching hearts and minds and serving as an anchor point. It should include a clear stance on anti-racism in your role as employer and service provider.

A clear strategy to engage and empower people, specifically those closest to the issue being addressed, such as people with experience of racism and discrimination, racialised inequality, and those who understand how systemic racism operates. Gaining the commitment of the wider workforce on this agenda will also be important.

Strategic outcomes that clearly outline the specific changes and impact to be achieved in the lives of minority ethnic people and communities. Your strategic outcomes should align with, and help you achieve, your mission and vision.

Specific outcomes, actions, deliverables and indicators for each strategic outcome.

The NHS East of England Race Strategy (p12) is a good example of an anti-racism 'plan on a page'. Other examples of anti-racism plans are included in the 'actionable insights & resources' section in Annex 5. Annex 6 contains checklists to support planning, as well as reflection/discussion prompts.

5.2 Suggested steps to developing your plan

One approach is to 'aim big, but start small' to ensure you can make early progress and build momentum.

Establish leadership and governance arrangements that provide visibility at Board level and strong accountability across the organisation.

- Consider the vision and underpinning principles, in particular, that it is everyone's responsibility to proactively embed an anti-racism approach;
- Where possible, ensure leadership and governance arrangements are embedded within existing arrangements.

Put in place a process for bringing together Health Board data and wider evidence to understand the racialised inequity experienced by your workforce and minority ethnic communities in your area.

- Consider the data and evidence presented in Annex 1, the actionable insights and resources in Annex 5, and the Framework for Action areas of focus and enablers;
- Engage with your workforce and patients to gather further insights, and to understand the evidence from a range of perspectives;
- Assess the quality of your available data, gaps, action needed to improve it.

Actively and respectfully involve minority ethnic people (workforce and patients) in identifying the immediate challenges and priorities for improvement.

- Gather insights on what people have already told you about their experiences of racism, discrimination and disadvantage as a member of staff, or relating to accessing services;
- Ensure your plans are informed by people who have experienced racism, and by those who have insights into how racism operates. Make use of staff networks and surveys to gather insights and involve diverse voices;
- Consider intersectionality, seeking to understand how experiences of disadvantage within already marginalised groups (e.g. minority ethnic women) compound and differ to help you identify and address hidden structural barriers;
- Consider how others addressed similar challenges to gain insights about what has worked, and what hasn't.

Annex 5 contains resources to support meaningful participation and co-production. The Wellcome Anti-racism toolkit (p.12) also contains useful content.

Agree the strategic priorities for your organisation, aligned to national priorities (see framework for action), and agree the outcomes and progress indicators.

- In collaboration with minority ethnic staff and patients or parents, identify your indicators of progress towards the changes and outcomes to be achieved in the lives of your minority ethnic workforce and patients;
- Use your authority to ensure that measurable progress towards those goals is made and that progress is accounted for.

Use the anti-racism plan as a living document. Agree how it will be reported on and scrutinised. Consider how best to involve minority ethnic staff and communities in this scrutiny and review process.

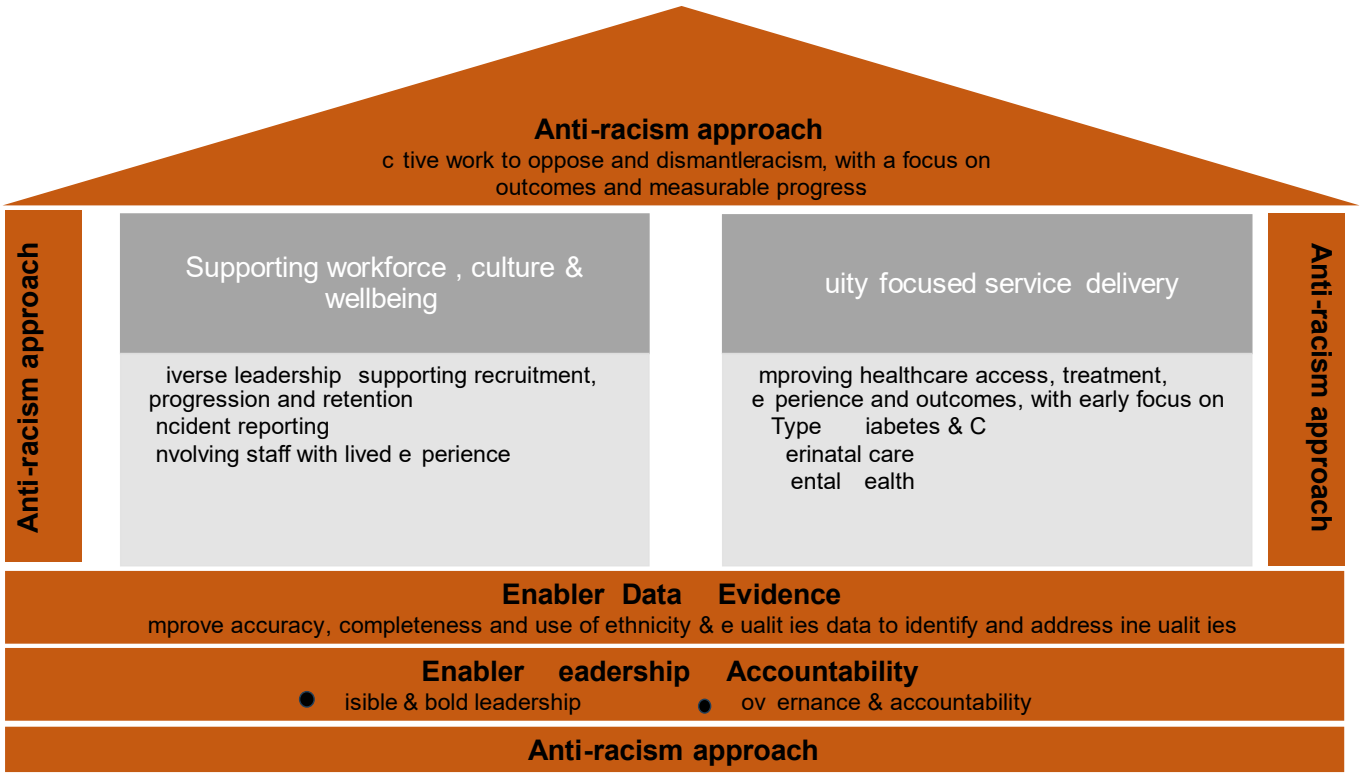
- Ensure there is clear and appropriate accountability at all levels for the plan;
- Test potential solutions and approaches, using your indicators of progress and data to assess the impact and refine your action and plan;
- Provide opportunities for those impacted, particularly those with lived experience, to receive updates and have the opportunity to scrutinise and provide challenge.

6. Framework for action

[20 min read] This section will give you an understanding of:

- The framework for action, its purpose and focus on workforce and service delivery;
- What we mean by an anti-racism approach,
- The importance of strong leadership, accountability, data and evidence in enabling effective anti-racism action, as well as concrete actions to embed anti-racism;
- Suggested areas of focus and actions.

6.1 What is the framework for action?


Anti-racism approach
c tive work to oppose and dismantleracism, with a focus on outcomes and measurable progress
Anti-racism approach
Supporting workforce , culture & wellbeing
iverse leadership supporting recruitment, progression and retention
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Type iabetes & C
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mprove accuracy, completeness and use of ethnicity & e ualit ies data to identify and address ine ualit ies
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Anti-racism approach

Figure 2: Framework for action to address racialised inequalities in healthcare through an anti-racism approach

The framework for action sets out current areas of focus based on Expert Reference Group on Covid-19 and Ethnicity (ERG) recommendations and existing evidence of racialised healthcare inequalities in perinatal care.

The framework has a twin focus on workforce and service delivery:

- Under **workforce, culture & wellbeing**, there are three specific areas of focus: diverse leadership (recruitment, progression and retention), incident reporting and involving staff with lived experience. These are based on feedback from the NHS Ethnic Minority Forum and what we know about lack of diversity in more senior roles.

- Under **equity-focused service delivery**, there are three specific areas of focus: Type 2 Diabetes (T2D) and Cardio-Vascular Disease (CVD) prevention, perinatal care and mental health.

We have also identified key enablers: **data and evidence**; and **leadership and accountability**. Suggested action in these areas also aligns with ERG recommendations and feedback we have received, including from the NHS Ethnic Minority Forum.

The purpose of the framework is to support alignment of national and local action, and to guide Board prioritisation in tackling racialised healthcare inequalities, taking an anti-racism approach. As we said earlier, we recommend that anti-racism plans align with this framework. We do not expect Boards to cover all areas of focus in 24/25. Rather we would ask Boards to be ambitious and take the framework into account when agreeing priorities for local anti-racism plans, and build from there. Ultimately we are working towards an anti-racist healthcare system and organisations in Scotland.

6.2 Embedding an anti-racism approach

Anti-racism is the active work to oppose racism and to produce racial equity – so that racial identify is no longer a factor in determining how anyone fares in life. Being anti-racist means supporting an anti-racist policy through your actions. An anti-racist policy is any measure that produces or sustains racial equity.

(Kendi (2019), and MP Associates, Centre for Assessment and Policy Development, and World Trust Educational Services (2020)

Evidence shows that inequalities exist for racialised minority groups – not because of individual prejudices - although these can be a contributing factor - but because our society and systems were not designed with racialised minority groups in mind. An anti-racism approach is about our organisations, and individuals within our organisations, recognising and acknowledging that racism exists in our systems and purposefully working to change those systems, attitudes, and behaviours so that everyone receives equitable treatment.

An anti-racism approach needs to wrap around and be woven into all of our work. This means being pro-active and taking concrete action to oppose and dismantle racism in all its forms, in everything we do.

"Anti-racism is not just about changing what we do, it is about changing how we do it." (Wellcome Anti-racist principles, guidance and toolkit)

We recognise that there is more to be done beyond the areas identified in the framework. We would therefore like to echo Professor Sir Michael Marmot and encourage Boards to 'do something, do more, do better':

Do something. If you are not doing any work on anti-racism yet, do something that will make a tangible difference. The areas listed in the framework are a good place to start because they relate to existing recommendations, commitments and evidence.

Do more. If you are already doing some work on anti-racism, do more. For example, you might already have an anti-racism focus for workforce and leadership, but might not have embedded it in service delivery or data collection and use, so this would be a natural next step for you.

Do better. If you are already focusing on all of those areas, we encourage you to consider scope to improve the way you embed anti-racism so that it becomes 'business-as-usual' and/or areas that are not included in the current iteration of the framework.

6.3 e adership and accountability

Leaders play an immense role in fostering – or damaging – racial inclusion efforts by virtue of their positional power and influence on the organisation's culture, values and ethics. To ensure that change is long term and sustainable, organisations and leaders need to uncover and address racial equality barriers. Traction requires leadership and sustained action…(Developing an anti-racism strategy, CIPD)

Leading to achieve racial equity, or anti-racism leadership, requires a deep and sustained commitment to look racism in the eye and using your authority to ensure measurable progress is made towards racial equity, and that progress is accounted for.

Professor Kevin Fenton has advocated three important dimensions of anti-racism leadership consistent with what others have said.

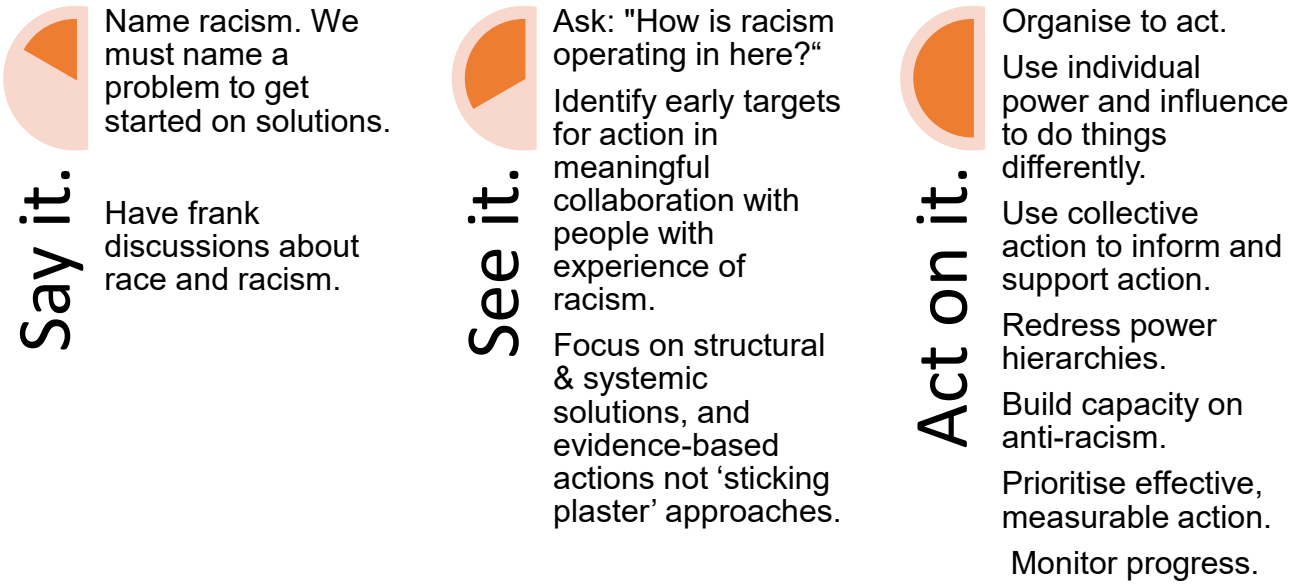
Say it.
Name racism. We must name a problem to get started on solutions.
Have frank discussions about race and racism.
See it.
Ask: "How is racism operating in here?"
Identify early targets for action in meaningful collaboration with people with experience of racism.
Focus on structural & systemic solutions, and evidence-based actions not 'sticking plaster' approaches.
Act on it.
Organise to act.
Use individual power and influence to do things differently.
Use collective action to inform and support action.
Redress power hierarchies.
Build capacity on anti-racism.
Prioritise effective, measurable action.
Monitor progress.

Figure 3: Say it, See it, Act on it. (Adapted from A public health approach to incorporating anti-racism and structural discrimination in tackling racial and ethnic health disparities, Professor Kevin Fenton, and the CRER anti-racist policy making in Scotland review)

Suggested actions:

- **Make an explicit, visible commitment to anti-racism** by senior leadership and a plan for sustained engagement with staff.
- **Strengthen governance and accountability**. This includes Board oversight and approval of the anti-racism plan, regular discussion and scrutiny of progress. Prioritise effective, measurable action. The Board is supported by lived experience and anti-racism expertise.
- **Diversify decision-making spaces.** Action to ensure the Board and other decision-making structures involve minority ethnic staff and are increasingly representative of the

community. To be meaningful, involvement must be respectful, inclusive and result in tangible change and impact.

- **Build understanding and capacity on anti-racism.** Commitment to sustained anti-racism training and development for all leaders, including training on cultural competence. This recognises that it is not the responsibility of minority ethnic people to educate others.

6.4 Data and evidence

> *"Good data are critical for monitoring equity of access and outcomes, generating high-quality evidence and research on inequalities at a population level. Only by progressing equalities data collection and analysis will it be possible to measure and monitor racialised health inequalities." (Public Health Scotland)*

Incomplete or inaccurate recording of race and ethnicity data obscures the extent of inequalities experienced by and between different minority ethnic groups. As such, it undermines efforts to identify and address inequalities experienced by staff and patients. It is therefore vital to improve the recording, collection, and use of race and ethnicity and wider equalities data in healthcare and workforce datasets. Public Health Scotland (PHS) have recently published a range of resources for patients and staff, to support improvements in equalities data collection, including race and ethnicity data. This is based on evidence of key barriers and best practice, including:

- Racism and discrimination are the main reasons for a refusal or reluctance to share race and ethnicity and equalities information.
- People are also less likely to share their equalities data if they feel healthcare settings are not inclusive, inaccessible, and/or that they are not listened to or respected.
- People feel more confident to share their data if they have clear, accessible information on why data is collected, and how it will be used and kept safe from potential harmful use.
- Race and ethnicity must be self-identified and not assumed based on race, nationality, visual appearance or any other factors
- Staff tasked with collecting equalities data, including data on race and ethnicity, may lack confidence in asking for this data, feel afraid of getting things wrong or having to deal with a negative response, and may not know why they are collecting the data and how it would be used.

Suggested actions:

- **Build understanding / confidence –** share PHS resources with staff and patients.
- **Monitor and improve levels of completeness and accuracy** and of equalities data collections, with an explicit early focus on race and ethnicity data.
- **Take steps to foster an inclusive culture** for staff and patients. People are less likely to share their data if they feel healthcare settings / workplaces are not inclusive.

6.5 Workforce

An anti-racism approach in the workplace will ensure that there is:

- Appropriate training for everyone;
- Visible and accountable leadership;
- Direct engagement with minority ethnic staff;
- Psychological safety to report incidences when they occur.

For an anti-racism action plan to work, staff need to feel comfortable, confident, and safe to speak up about issues – whether about discrimination, bullying or racial harassment they are themselves facing, or issues they see in patient care - without fear of repercussion.

Staff equality networks can be a useful way for staff to feel supported and can provide advice to help shape policies and interventions, from a lived-experience perspective.

Seeing more diverse staff in senior and leadership positions can help the workforce to believe that the organisation values diversity. This is one of the key priorities of the National NHS Ethnic Minority Forum, the national forum that represents staff from diversity networks across Scottish Health Boards.

The delivery of anti-racism plans links to wider priorities for the NHS including Anchors, staff retention, reducing sickness absence, improving wellbeing, longer-term recovery and service reform. Creating a sustainable health service is fundamentally linked to developing a positive working environment for all of our staff.

Embedding an anti-racism approach will also help retain our growing numbers of International medical and nursing staff, as well as equipping the NHS to support patients and staff from our increasingly diverse communities in Scotland.

Suggested actions:

- **Prioritise meaningful involvement** of minority ethnic staff in the development and evaluation of anti-racism plans, giving them the time and support required to do so.
- **Focus on recruitment, retention and progression to improve workforce diversity, particularly at senior and executive levels**. This might include training and support, and diverse panels.
- **Improve reporting of incidents** related to racism, discrimination, bullying and harassment. Understand issues with reporting channels and ensure staff feel supported and safe to report incidents.

6.6 Equity-focused service delivery

"Inequities are the worst type of unwanted variation in a system – variation linked to the complicated history and reality of racism, classism, sexism, ableism, ageism and other forms of oppression. Quality improvers have a role to play and tools to use in health care systems and communities to end inequities." (Institute for Healthcare Improvement)

Inequities are systemic, avoidable, predictable and unjust differences in access, experience, treatment and outcomes between individuals and across populations. Improving health and care requires an intentional focus on equity so that each individual has a fair opportunity to achieve their full health potential.

Equitable care can be defined as 'care that does not vary in uality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status'.

Equity-focused service delivery is therefore about reducing variations in access, experiences, treatment and outcomes between individuals and population groups through evidence-informed, culturally and gender appropriate interventions.

Our overall aim is to improve equity of access, experience and outcomes across the entire care pathway – primary and secondary. Improving the cultural appropriateness of services is a core part of this work.

As we indicated earlier, our areas of focus are based on Expert Reference Group on Covid-19 and Ethnicity recommendations and evidence of racialised healthcare inequalities in perinatal care. Below, we set out suggested action for all of these as well as some service-specific guidance.

Suggested actions for equity-focused service delivery:

- **Equality Impact Assessments (EQIAs) –** early completion to inform changes to, or development and delivery of, services and decisions at every stage. Regular updates and reviews.
- **Maximise use of PHS equalities data resources** to improve race & ethnicity data collection and use data to monitor inequalities and inform improvements to patient care.
- **Establish mechanisms for collaboration** with the third sector, community and faith groups, and minority ethnic staff to improve cultural appropriateness, and address barriers to access.

Equity-focused service delivery: Focus on Type 2 Diabetes (T2D) and Cardiovascular Disease (CVD) prevention

T2D is associated with an approximate doubling of CVD risk compared with the risk for people without T2D. This is due to a combination of factors affecting those with T2D such as high blood glucose, obesity (specifically excess ectopic fat), dyslipidaemia and high blood pressure. Cardiometabolic dysfunction is a feature of T2D with diagnosis at a younger age predicting a more aggressive disease process. The prevention and treatment of CVD and T2D is very similar therefore integrated approaches to supporting people with these conditions is sensible and reflects a person-centred approach.

Suggested actions for T2D include those outlined above plus:

- **Understand inequalities in the receipt of care** for your Health Board area including, for example, HbAiC monitoring.
- **Promote and use PHS equalities data resources** to improve race and ethnicity data on the weight management T2D prevention core dataset.

Equity-focused service delivery: Focus on Perinatal care

Inequalities in outcomes for mothers and babies from Black and minority ethnic backgrounds are well-evidenced – see Annex 1.

Suggested actions for perinatal care include those outlined above plus:

- **Understand the demography of your local population**, utilising local and national data to identify inequities and inequalities of outcomes for service users from minority ethnic communities in your Health Board area.
- **Identify and understand any variation in quality of experience**, utilising available tools, including local maternity engagement groups (e.g. maternity voices partnership) and feedback via Care Opinion.
- **Adopt a proactive approach** to gaining feedback from the experiences of service users, particularly from seldom heard communities.
- **Understand trends** through use of the Perinatal Mortality Review Tool (PMRT) and review of Significant Adverse Event Reviews (SAER).
- **Undertake focused quality improvement** where opportunities for improvement activity are identified. Make use of the support packages offered through participation in the **SPSP Perinatal programme**.

Equity-focused service delivery: Focus on Mental Health

The Mental Health Equality Evidence Report and Annex 1 set out evidence of specific inequalities in access, experience and outcomes faced by minority ethnic people and communities in the UK and in Scotland.

Suggested actions for mental health include those outlined above plus:

- In identifying and planning improvements, consider a specific focus on **services that provide support for people experiencing distress and crisis** (priority 4 of delivery plan 2023-2025); and the **quality of care and treatment provided** (priority 7)
- **Build an understanding of barriers to access** in your local area. These may include stigma, lack of awareness of and trust in formalised services, language and cultural barriers, and lack of culturally appropriate services.
- **Build understanding of experiences,** especially of the quality of care and treatment provided, in your local area.

ANNEXES TO ANTI-RACISM PLAN GUIDANCE

Annex 1 Key evidence

Workforce

The B 's (0) report Delivering Racial Equality in Medicine provided a high level overview of barriers to e uality their members, drawing on findings of the B 's 'Racism in edicine' survey which found that:

- Just over 90% of Black and Asian respondents, 73% Mixed and 64% of White respondents said racism in the medical profession is an issue.
- 76% of the doctors surveyed experienced racism at least once in the last two years, with 17% experiencing these racist incidents on a regular basis.
- There was a low-level of reporting for racist incidents, with 71% of doctors who experienced racism choosing not to report due to a lack of confidence that the incident would be addressed or a fear they would be labelled as 'troublemakers'

MDDUS surveyed their members (international recruits) in 2023 and produced the report We Hear You: Challenging Racist Microaggressions on the experience of international medical staff.

- 58% of international medical graduates report having been subject to racist microaggressions
- 66% of international medical graduates did not report incidents of racist microaggressions because they had no confidence their concerns would be taken seriously
- 62% of members in the medical field who reported witnessing racist microaggressions against colleagues did not report them

The King's Fund (2020) undertook a research study of workforce race inequalities and inclusion in (UK) NHS providers.

They found that ethnic minority staff are more likely to report bullying, harassment and abuse from patients and colleagues; and they are more likely to enter into the formal disciplinary process:

- 15.3 per cent of ethnic minority staff report experiencing discrimination at work from a manager, team leader or other colleague – more than double the proportion of white staff reporting discrimination (6.4 per cent)
- 69.9 per cent of ethnic minority staff report that they believe their trust (employer) provides equal opportunities for career progression or promotion, compared with 86.3 per cent of white staff

This report also looked at how NHS providers were working to better support staff and address inequalities in relation to staff progression (section 5); and the importance of leadership and allyship (section 6).

Equity-focused service delivery

The NHS Race and Health Observatory carried out a Rapid Evidence Review into ethnic inequalities in healthcare (2022) which showed that:

- Ethnic inequalities in access to, experience and outcomes of healthcare are longstanding problems in the NHS. Inequities experienced include:
    - lack of appropriate treatment for health problems,
    - poor quality or discriminatory treatment from healthcare staff,
    - a lack of high quality ethnic monitoring data recorded and used,
    - lack of appropriate interpreting services,
    - delays in, or avoidance of seeking help for health problems due to fear of racist treatment from NHS healthcare professionals.
- Ethnic healthcare inequalities are rooted in experiences of structural, institutional and interpersonal racism.
- The review focused on mental healthcare, maternal and neonatal healthcare, digital access, genetic testing and genomic medicine and the NHS workforce.

Type 2 Diabetes and cardiovascular disease

Scotland

- Receipt of routine diabetes care was found to be lower in visible minority ethnic groups compared to white groups, in both the short- and medium-term following diabetes diagnosis. Differences were most pronounced for people in the African, Caribbean or Black, Indian and other ethnicity groups (Arab and any other ethnic group). (Scottish Diabetes Research Network epidemiology group, 2024)[1]
- Cariovascular disease (CVD) is a leading cause of morbidity and mortality in Scotland, and a significant contributor to inequalities in life expectancy.

UK wide

- South Asian groups are up to six times more likely than in white groups to develop T2D and have higher mortality from diabetes. Diabetes prevalence in Black groups is up to three times higher than in the white population and they have higher mortality from diabetes. (The Health Of People From Ethnic Minority Groups In England | The King's Fund (kingsfund.org.uk)
- Black groups have higher-than-average incidence of and mortality from hypertension and stroke and have strokes at a younger age. However, in contrast to South Asian groups they have a lower risk of heart disease compared to the majority of the population (The Health Of People From Ethnic Minority Groups In England | The King's Fund (kingsfund.org.uk)

[1] Scheuer SH, Fleetwood K, Wild SH, Jackson CA. Ethnic disparities in quality of diabetes care in Scotland: A national cohort study, Diabet Med, 2004. Accessed at Ethnic disparities in quality of diabetes care in Scotland: A national cohort study (wiley.com) on 27/06/2024

- Compared to White people, minority ethnic groups have a higher prevalence of diabetes, poorer glycaemic control and higher risk of complications. However, receipt of routine diabetes care was lower in minority ethnic groups compared to majority White groups, in both short-and medium-term following diabetes diagnosis. (Ethnic disparities in quality of diabetes care in Scotland: A national cohort study - Scheuer - Diabetic Medicine - Wiley Online Library)

Perinatal care

Inequalities in outcomes for mothers and babies from Black and minority ethnic backgrounds are well-evidenced. The most recent Mother and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports highlight that, across the UK:

- Black women are almost four times more likely to die during the childbearing year, while Asian women are almost twice as likely to die, than their majority White counterparts ((MBRRACE-UK, 2023)
- Inequalities in mortality rates by deprivation and ethnicity remain, with stillbirth and neonatal mortality rates considerably higher for Black and Asian women than for white women. The impact of inequalities by ethnicity can be compounded by the intersection of deprivation.

Neonatal mortality

- There are significant ethnic inequalities in neonatal mortality in the UK. MBRACE-UK reported that neonatal mortality rates for 2021 continued to be higher for bablies of Black and Asian ethnicity compared with babies of White ethnicity. (Source: Neonatal mortality review: February 2024, Healthcare Improvement Scotland)
- In 2021 in the UK, Black babies were over twice as likely to be stillborn, and Asian babies over 50% more likely, compared with White babies.
- The neonatal death rate among babies born at 24 weeks gestation and over was the lowest in white babies, and highest amongst Black and Asian babies. (The Sands Listening Project – Learning from the experiences of Black and Asian bereaved parents, 2023)

Other key findings

- Refugee and asylum-seeking women in the UK have a higher risk of perinatal mental health problems and postnatal depression. (Amma Birth Companions Birth Outcomes and Experiences Report)
- Muslim women from racialised minority communities have reported poorer experiences during labour, delivery and postnatal periods, such as being denied choice, inaccessibility of information, lack of cultural competence, compassion, respect and dignity and not being listened to (Invisible – Maternity Experiences of Muslim Women from Racialised Minority Communities, uslim Women's Network UK, 0)

- The birthrights inquiry into racial injustice and human rights in UK maternity care revealed common themes across the evidence including:
  - Lack of physical and psychological safety
  - Being ignored and disbelieved
  - Racism by caregivers
  - Dehumanisation
  - Lack of choice, consent and coercion
  - Structural barriers
  - Workforce representation and culture
- The birthrights inquiry report recommends a commitment to anti-racism, that the maternity curriculum and guidance are decolonised, including Black and Brown women in decision-making, creating safe, inclusive workforce cultures and dismantling structural barriers to racial equity through national policy change.

In Scotland

- Pregnant women of African and Caribbean or Black ethnic backgrounds are more likely to reside in deprived areas compared to pregnant White majority women. (Amma Birth Companions Birth Outcomes and Experiences Report)
- During 2021-22, birth companions reported practice issues or discrimination, including lack of attention and delayed pain relief, inadequate consent & communication, insensitive and disrespectful behaviour, and inadequate support and dismissive attitudes in 37% of 76 recorded cases. Issues with interpreting were identified in 74% of these cases. ((Amma Birth Companions Birth Outcomes and Experiences Report)
- In Scotland, recording of maternal ethnicity on the SMR02 dataset has historically been around 80% with the remaining 0% being 'not known / refused / not provided'. t is therefore not possible to draw any conclusions regarding the impact of ethnicity, and / or any changes associated with ethnicity in Scotland on neonatal mortality in 2021/22. (Source: Neonatal mortality review: February 2024, Healthcare Improvement Scotland)
- Public Health Scotland (PHS) reports in its latest *Births in Scottish Hospitals* publication: The percentage of pregnancies booked by 12 weeks in 2023 was lower for ethnic minority populations compared to those from the white ethnic group (94%), with the lowest percentage for those of African ethnicity (70.5%).

Mental Health

The experiences of minority ethnic people in Scotland relating to mental health vary widely, and are often under-represented in research around mental health indicators and outcomes. In general, there is a complex picture of rates of mental health among minority ethnic groups which indicate that some groups have higher risk of experiencing mental illness. This is linked to numerous social determinants, including experiences of racialised and generational trauma and discrimination, and a higher likelihood of living in areas of deprivation. Minority ethnic groups may have different experiences in accessing services, encountering barriers such as mental health stigma and a lack of access to, and availability of, culturally appropriate and sensitive support. (Mental Health Equality Evidence Report, Scottish Government 2023).

Inequalities in access, experience and outcomes of mental healthcare

- There are barriers to seeking help for mental health problems due to distrust in primary and mental health care providers, and a fear of being discriminated against (NHS RHO Rapid Evidence Review)
- Other barriers to access include mental health stigma within some minority ethnic communities, lack of awareness of available services, lack of trust in formalised mental health services, and language and cultural barriers. (Mental Health Equality Evidence Report, Scottish Government 2023)
- Many Gypsy, Traveller and Roma people have experienced trauma, discrimination and racism from a very early age. Many of their children are also in state care, adding further trauma and a mistrust of statutory services. (NHS Race and Health Observatory (RHO), Inequalities in Mental Health Care for Gypsy, Roma and Traveller Communities (2023)
- Accessing adult mental health services in Scotland remains slow and complicated for many people. In particular, minority ethnic groups, people living in rural areas and those in poverty all face additional barriers. Mental health services are less accessible for minority ethnic groups because of language, cultural barriers and a lack of culturally appropriate services. (Audit Scotland, Adult mental health, 2023; (Public Audit Committee, 2024).)

The Mental Welfare Commission for Scotland (2021) found:

- Differences in how the Mental Health Act is applied and that people who were black, or of mixed or multiple ethnicity were perceived a greater risk to themselves and others, whereas all categories of white people were more often perceived a risk to themselves.
- A higher proportion of emergency detentions starting in the community for black people (54%) compared to white Scottish people (41%).
- Some minority ethnic people and refugees described difficulties in accessing treatment; some described a high level of stigma of mental illness in their communities.
- Nearly a third of the 320 staff who responded to a survey reported witnessing racism.
- In relation to cultural competent service delivery, barriers included a lack of awareness of issues, lack of senior representation, gaps in training and inade uacy of ‘one-off’ diversity and equalities training modules, location of equality and diversity lead role.
- Other issues raised included limited understanding of how race and ethnicity data collected was used, and a lack of data.

Race Equality Foundation Mental Health Briefing: (UK)

- Research has repeatedly shown that minority ethnic communities have poorer experiences and negative outcomes within mental health care when compared to the majority population.
- The Covid-19 pandemic has had a disproportionate impact on minority ethnic communities, who have experienced higher levels of anxiety and depression rates than the white population.
- The reasons for this are multi-factorial; and there is overwhelming evidence that existing inequalities compounded by structural racism and discrimination at the face of accessing and utilising services have played a key role in the exacerbation of these inequalities.

Asylum seekers and refugees
Asylum seekers and refugees are disproportionately likely to experience mental health impacts from trauma and a range of post-displacement stressors, including social isolation, poverty, lack of access to resources and discrimination (Mental Health Equality Evidence Report, Scottish Government 2023)

Gypsy Traveller Health

It is widely accepted that Gypsy/Traveller communities typically experience poorer health outcomes and shorter life expectancy than the general population. Scottish Census data, for example, demonstrates that this population is approximately twice as likely to report a limiting long-term health problem or disability compared to the White Scottish population, and is approximately 3 times as likely to rate their health as being either bad or very bad. These health inequalities are likely attributable to a range of broader social inequalities experienced by Gypsy/Traveller communities, including relatively poor living conditions, high rates of homelessness, low educational attainment, social exclusion and stigma and discrimination.

Mental Health: Evidence collated in a report by Friends, Families and Travellers relating to Gypsy, Roma and Traveller people across the UK indicates that Gypsies and Travellers have an increased likelihood of experiencing depression and anxiety and are six times more likely to die by suicide than the general population.

Inequity in accessing services and support
Reports from third sector organisations and NHS Scotland highlight the challenges in accessing primary and specialist health care, including accessing services without fixed address or proof of identification; longstanding experiences of discrimination and resulting mistrust of services, particularly in the absence of culturally appropriate service delivery; difficulty in establishing continuity of care within mobile lifestyles and difficulties in communication, particularly for those with low or no literacy and knowledge of navigating healthcare systems.
(Mental Health Equality Evidence Report, Scottish Government 2023)

Covid-19 and wider social determinants

Covid-19 shone a spotlight on pre-existing inequalities experienced by many minority ethnic groups, both in Scotland and in the UK. For example:

- In Scotland, rates of hospitalisation or death were estimated to be around fourfold higher in Pakistani and mixed groups, and around twofold in Indian, other Asian, Caribbean or Black, and African groups compared to the White Scottish group. (Monitoring ethnic health inequalities in Scotland during COVID-19 (publichealthscotland.scot))
- Minority ethnic healthcare workers in the UK accounted for 64% of deaths of nursing and support staff, and 95% of medical staff.(Healthcare workers from ethnic minorities felt unsafe during COVID (nihr.ac.uk))

Poverty in Scotland

Research from the Joseph Rowntree Foundation (JRF) shows that for minority ethnic people (excluding those from a White minority background):

- Poverty rates are significantly higher than for White families; in 2019–20 the poverty rate was more than twice the rate found for White people (52% compared to 19%).
- Over half of minority ethnic children live in poverty, five times the 03 target and twice the poverty rate found for all children. inority ethnic children now make up 7% of children in poverty, but around 8% of all children.
- The in-work poverty rate for minority ethnic people is more than three times the rate seen for White people, 40% compared to 12%.
- Asian applicants to Social Security Scotland are least likely to have their applications approved and are the largest group of minority ethnic applicants.

[Source: *Poverty in Scotland 2023 (Joseph Rowntree Foundation)* and *Ethnicity, poverty and the data in Scotland (JRF, 2021),*

To note: The Joseph Rowntree Foundation (JRF) definition of minority ethnic differs from the one used by the Scottish overnment in that it e clud es people from a 'White other' background.]

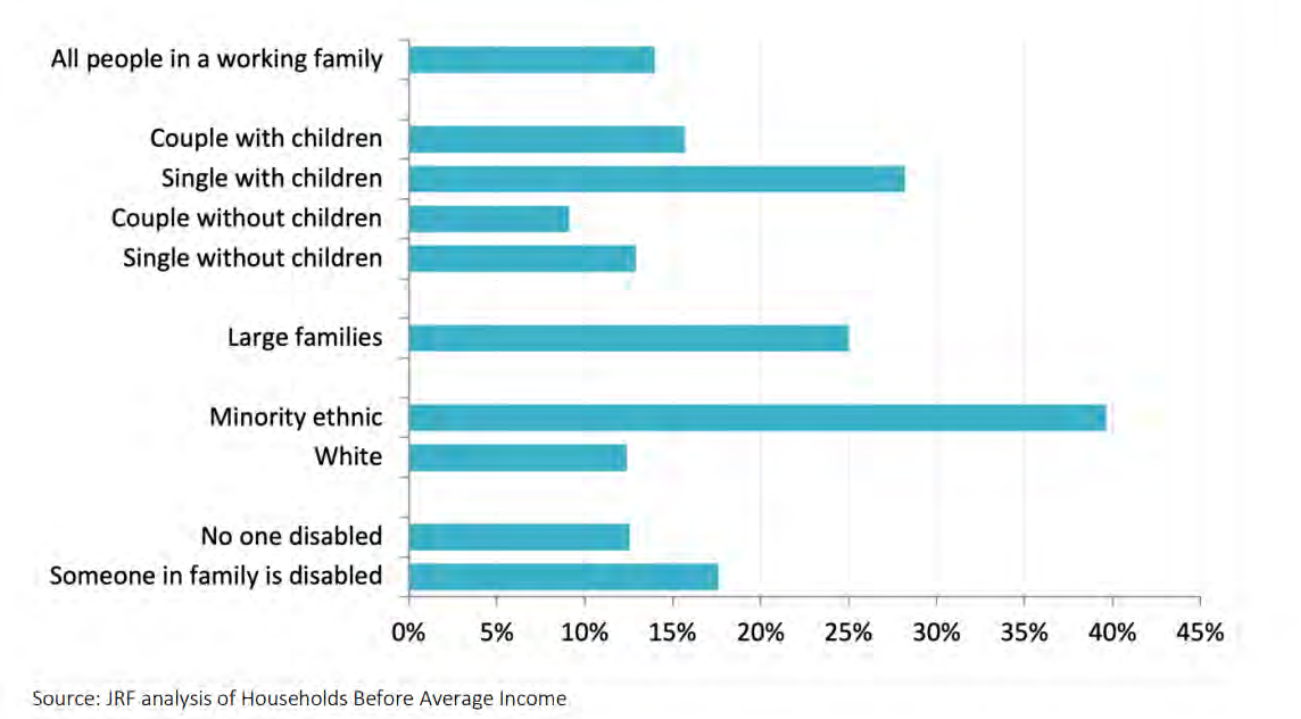

Figure 4: Risk of poverty for people in working families, by family and individual characteristics (Source: JRF analysis of Households Before Average Income.)

Scotland's population in 2022

- The percentage of people in Scotland with a minority ethnic background increased from 8.2% in 2011 to 12.9% in 2022. This is a larger increase than over the previous decade (from 4.5% to 8.2%).
- Scotland's Census asked people to choose the option that best described their ethnic group or background. The majority of people in Scotland chose 'Scottish' (77.7%) or 'Other British' (9.4%) within the White category. In 2022 these groups together made up 87.1% of the population.
- ' inority ethnic group' is used in Scotland to refer to all other ethnic groups that are not included in the White Scottish or British group, including ethnic groups that are in the White category on the census form such as Irish, Polish, Gypsy/Traveller, Roma and Showman/Showwoman.[2]
- There were increases across several minority ethnic groups as shown in figure 1 below.
- The largest minority ethnic groups are the 'Other white' and olish groups, at .9 % and 1.67% of the population respectively.
- round three out of four people in the 'Other white' category had European heritage – they wrote in ' uropean', or wrote in a uropean country to define their ethnic background.
- Groups from Pakistani ethnic backgrounds made up 1.34% of the population in 2022.
- The percentage of people born outside the UK increased from 7.0% to 10.2% between 2011 and 2022. ow ever, in 0 , 7.8% of Scotland's population aged between 0 and 39 were born outside the UK. Without migration we would therefore have fewer people in younger age groups.
- Geography also plays a significant role in the ethnic diversity in the population. Glasgow is the most ethnically diverse place in Scotland, with one in five Glaswegians coming from a 'global majority'[3] background**.** This marked a 75% increase since 2011 - a rise partly e p lained by la sgow's booming young population. Edinburgh, Aberdeen and Dundee also had high levels of ethnic diversity.
- Rural Scotland tended to be much less ethnically diverse, with just 2.1% of the rural population coming from a 'global majority' background, and 3. % from a white minority background.[4]

[2] Scotland's Census 0 - Ethnic group, national identity, language and religion | Scotland's Census (scotlandscensus.gov.uk)
[3] The term 'global majority' is increasingly used to refer to those from non-white ethnic communities because it is considered a more positive affirmation of the majority representation of these groups in a global context.
[4] Scotland's Census 0 : What do the latest statistics tell us about minority ethnic groups in Scotland? — CRER

Annex 2 Strategic context

Expert Reference Group on Covid-19 and Ethnicity recommendations
The need for NHS Board Chairs to have specific anti-racist objectives is in direct response to recommendations made by the Expert Reference Group on Covid-19 and Ethnicity, which were accepted by Ministers.

Development of anti-racism objectives are also supported by recommendations made by the Equality and Human Rights Commission, British Medical Association and Royal College of Nursing who all conducted their own independent investigation into inequalities experienced by health and care staff and patients from minority ethnic backgrounds, as highlighted by the Covid-19 pandemic.

Programme for Government (PfG) 2024-2025
The current rogramme for overnment (f) 'Serving Scotland' commits to working with partners across the public and third sector to embed anti-racism and advance the Race Equality Framework, including delivery of the Anti-Racism Observatory.

Race equality framework for Scotland 2016 – 2030 (REF)
The Race Equality Framework for Scotland 2016 to 2030 was informed through extensive engagement with communities, and remains the overarching strategic framework for the Scottish Government until 2030. Key principles underpinning the REF include:

- developing a society-wider awareness that race equality is not a marginal issue for Scotland, and that society is undermined when racial discrimination and racism are allowed to persist;
- tackling racism must focus on dismantling structures, behaviours and attitudes which contribute to or sustain inequality and discrimination in all its forms, including institutional, social and personal;
- racialised inequality is a product of discrimination and disadvantage.

Scotland's vision for health and home is that, by 030, minority ethnic communities in Scotland have equality in physical and mental health as far as is achievable, have effective healthcare appropriate to their needs and experience fewer inequalities in housing and home life. Key goals to enable achievement of this vision include:

- Goal 26: Minority ethnic communities and individuals experience better health and wellbeing outcomes.
- Goal 27: Minority ethnic communities and individuals experience improved access to health and social care services at a local and national level to support their needs.
- Goal 28: Scotland's health and social care workers are better able to tackle racism and promote equality and community cohesion in delivery of health and social care services.
- Goal 29: Scotland's health and social care workforce better reflects the diversity of its communities.

Anti-racism in Scotland Progress review
The Anti-racism in Scotland Progress Review published in June 2023 provides an overview of Scottish Government commitments within the Race Equality Framework (2016-2030),

including the four public Health related goals (two related to population level health outcomes and access; and two related to Scotland's health and care workforce). It also acknowledges the need to address racism within our institutions and structures, and that this requires a anti-racism stance which proactively dismantles formal and informal structural, institutional and cultural processes that place minoritised groups at a disadvantage within Scotland in relation to the majority.

A Parliamentary debate on 10 June 2020, 'Showing Solidarity with Anti-racism', showed there is cross-Party support for tackling structural racism and advancing race equality. Since then, S 's Anti-racist employment strategy (2022), Anti-racism in Education Programme (AREP) contain explicit anti-racism statements and action.

Care and Wellbeing Portfolio

The policy principles underpinning the Care and Wellbeing Portfolio mirror Professor ichael armot's recommendations to reduce health inequalities. These have been updated to reflect the existence of structural racism in the UK and in Scotland, as highlighted by the pandemic, and the need to tackle climate change. s such, armot's recommendations and Care and Wellbeing Portfolio principles include a focus on tackling discrimination, racism and their outcomes.

National Performance Framework

Anti-racism approaches align to the following National Performance Framework Outcomes:

- **Health–** "We live long, health and active lives regardless of where we come from. We are all able to access world class, appropriate and free/affordable health, social care and dental services….. We use evidence intelligently to continuously improve and challenge existing healthcare models. Our approach is integrated, preventative and person-centred. We are focused on resolving needs in order to achieve positive health, care and wellbeing outcomes."
- **Human Rights –** "We recognise the fundamental e uality of all humans and strive to reflect this in our day to day functioning as a nation. We stand together to challenge unfairness and our equalities legislation, law and practice are world leading. We uphold human rights, democracy and the rule of law, and our justice systems are proportionate, fair and effective. We provide the care people need with love, understanding and dignity".
- **Poverty –** "Scotland is a wealthy country and we have the resources, ability and commitment to provide a decent life for all our people. Through this outcome we will work together across political parties and sectors to identify and address the root causes of disadvantage and set in place the actions to eradicate poverty for good".

NHS Recovery Plan 2021-2026

This work aligns to the Principles for Safe and Effective Recovery as set in the NHS Recovery Plan 2021-2026, specifically: focus on the whole system, quality, values & experience, improved population health, services that promote equality, value and support the workforce.

Legislation and human rights obligations

We have legal and human rights obligations to monitor and improve the experience of staff and patients with protected characteristics. Race discrimination, or unfairly disadvantaging

someone for reasons related to their race, has been illegal in the UK since 1976. The Equality Act 2010 definition of race includes colour, nationality, ethnic and national origins.

Chiefly, under the Equality Act 2010 (Scotland) Public Sector Equality Duty (PSED)[5] all public bodies are obligated to:

- eliminate unlawful discrimination, harassment, victimisation and any other unlawful conduct prohibited by the act
- advance equality of opportunity between people who share and people who do not share a relevant protected characteristic
- foster good relations between people who share and people who do not share a relevant protected characteristic

The PSED operation review consultation analysis concluded that all bodies need to improve the regime of work carried out in respect to reporting under PSED. This guidance provides a road map to creating an effective plan for delivering on that legal obligation.

The development of effective anti-racism plans will also contribute to your Board's performance in ongoing National Performance Management outcomes and meet your responsibilities under the PSED in a meaningful way.

[5] Public Sector Equality Duty: specific duties in Scotland | EHRC (equalityhumanrights.com)

Annex 3 Scottish Government action

Leadership & accountability

Racialised Health Inequalities in Health & Social Care in Scotland Steering Group.
To support strong anti-racism leadership, Scottish Government established a senior Steering Group in 2022 to provide leadership, oversight and challenge in respect of the health and social care recommendations from the Expert Reference Group on Covid-19 and Ethnicity. The roup's broader aims are to pursue e uity of access, e perience and outcomes in health and care for minority ethnic people and communities, taking an anti-racism approach. It is co-chaired by the Director of Population Health and Director of Evidence at Healthcare Improvement Scotland. Core membership includes the Scottish o vernment's Chief edical Officer, i rectors and e puty i rectors from policy areas across Health and Social Care, the Chair of the NHS National Ethnic Minority Ethnic Forum, as well as representation from NHS Health Board Chief Executives including Public Health Scotland and Directors of Public Health.

The Steering Group is focussed on progress in areas set out in the Framework for Action.

Leading to change
Leading to Change complements leadership development and support at local levels for the health, social work and social care workforces in the public, independent and third sectors. To support Equality, Diversity, and Inclusion we have the following programmes:

- We are developing an Allyship Programme with the Leading to Change Programme Board and NES. The programme will increase awareness of allyship across the sectors, create spaces for discussion and further learning, and examples of good allyship.
- A Diversity Leadership at All Levels (DLAAL) Programme is being developed as part of a series of activities designed to support delivery of the Leading to Change Equalities Action Plan. NES are now exploring how to do this and will shortly present a paper outlining plans for delivery.

Data and evidence

Population level race and ethnicity data
Improving the quality and completeness of race and ethnicity data, alongside wider sociodemographic data, needs to be a high priority if we are to effectively identify and address racialised inequalities in health and social care, take targeted action and measure progress. We also need robust real-time data to respond effectively in times of crises. The inadequacy of race and ethnicity data was highlighted by the pandemic.

As part of the work being taken forward by the Racialised Health Inequalities in Health & Social Care Steering Group, a working group led jointly by Public Health Scotland and Scottish Government, has therefore been established to develop a cohesive approach to improving race and ethnicity data collection and use within health and social care, adhering to ethical and anti-racism principles, and ensuring our work is aligned to our new Data

Strategy for Health and Social Care – ‘ r eater access, better insight, improved outcomes: a strategy for data-driven care in the digital age’ (Feb 0 3).

The impetus for this work is the effective delivery and sustainable implementation of the recommendations made by the Expert Reference Group (ERG) on Covid-19 and Ethnicity in relation to race & ethnicity data in health and care. Specifically:

- Recommendation 3: Embedding ethnicity data within CHI as a central store / database
- Recommendation 7: Sustained, co-ordinated that builds on lessons learnt and embeds ethnicity data collection and use in NHS Scotland culture.
- Recommendation 8: Collection of ethnicity information at the time of GP registration
- Recommendation 9 (a): Minority ethnic people and communities to inform policy development and implementation to ensure the work meets the needs of Scotland’s diverse communities.
- Recommendation 9 (b): Increasing awareness and safeguarding measures in relation to racism and racialisation through data systems and processes.

Data Strategy for Health and Care
SG published its Data Strategy for Health & Social Care in February 2023. The 8 priority areas for actions are:

- Ethical approaches to data;
- Data access;
- Talent and culture;
- Information governance and cyber security;
- Technology and infrastructure;
- Information standards and interoperability;
- Creating insights from data; and
- Supporting research and innovation.

The Data Strategy states that privacy, particularly of protected characteristics like ethnicity, will be treated sensitively to prevent bias or discrimination. It commits to assessing the fairness and impartiality of data processes and work with experts in systemic racism, disability, and social policy to ensure appropriate analysis, and to mitigate bias and discrimination.

Early progress

- The collection of race and ethnicity data for Covid-19 vaccinations was introduced in November 2021, and is now routinely collected for Covid-19, influenza, shingles and pneumococcal vaccines, where a record is not already held.
- Through collective efforts of Scottish Government, territorial and national Boards, including Public Health Scotland, ethnicity data was assigned to 93% of covid and 90% of flu vaccine records respectively by winter 2022 programmes, up from around 65% in 2021.
- The data informed outreach programmes and local efforts to increase vaccine uptake in communities experiencing disproportionately poorer uptake.

Workforce, culture and wellbeing

Our aim is to create a workplace culture where staff feel safe, valued, and respected. By supporting staff wellbeing, investing in leaders, and ensuring our workplaces support diversity, we're helping improve public services overall. To do this we are investing in multiple streams of work to ensure that the NHS culture is supportive of all staff, regardless of their background and ensure staff have the psychological safety needed to report any adverse incidents. This includes:

- updating and improving current policies and procedures,
- creating new streams of work to address new and emerging issues, and
- improving recruitment, retention and progression for people with protected characteristics.

On 8 July 2024 we published the Improving Wellbeing and Workplace Cultures (IWWC) Publication which describes our vision and explains why activity across wellbeing, leadership and equalities are so important for improving working culture.

Early progress

We are taking a a firm anti-racism approach to improving workplace cultures. To support this we have taken the following actions:

- Coalition for Racial Equality and Rights (CRER) are working with the NHS to design and develop a suite of anti-racism capacity building resources for staff. The materials will support staff and managers to identify, discuss, and challenge racism in the workplace. To ensure the resources are tailored to address NHS specific challenges a survey gathering staff experience and understanding of racism was distributed in January 2024. The survey outcomes are helping shape the learning resources which are scheduled to be delivered by the end of 2024.
- NHS Board Chairs now have anti-racism objectives and Chief Executives will too. The objective is that all Boards implement anti-racism plans, to cover both workforce and racialised healthcare inequalities. The objectives and progress on the subsequent plans will be monitored through the Quarterly Annual Delivery Plan (ADP) reporting.
- We helped establish the NHS Staff Ethnic Minority Forum (EMF) in 2021. The EMF is a national forum that is mainly made up of members chairing or representing local race/ethnicity networks in health boards. We regularly collaborate with the EMF to develop and deliver policy and support for staff that is informed by lived experience. This includes supporting the development of the anti-racism resources as well as representation on internal Scottish Government steering groups. The EMF are publishing their first annual report in summer 2024.
- Demographic questions, including on ethnicity, are now included in the annual iMatter Health and Social Care Staff Experience Continuous Improvement Model questionnaires. The first demographic analysis was published on 1 August 2023 and will act as a benchmark for future monitoring of the staff experience through the lens of protected characteristics.
- In partnership with our delivery partner NHS Education for Scotland (NES), we have a Diversity Blog Series and we run "Diversity Coffee Connect" events which aim to provide opportunities to connect with colleagues across sectors and have meaningful

conversations about topics such as race, gender and the experiences of other marginalised groups.

- We are working to identify and map current support systems / services for NHS staff for reporting personal adverse incidents (e.g. violence and aggression, bullying and harassment, racist abuse, etc.) in the workplace. This includes after care and wellbeing support. We will also identify what, if any, further services, signposting or support staff need, as well as the types of cases employers receive and what, if any, training needs they have. This work will be linked in with sexual misconduct work and a review of relevant recommendations from the Women's e alth lan.

Equity-focused service delivery

Type 2 Diabetes and Cardiovascular Disease

The Scottish Government has committed to reducing racialised health inequalities in T2D and CVD.

Public Health Scotland will support the delivery of training to health boards to undertake equality impact assessments to help inform this work.

In recognition of the importance of addressing risk factors for cardiovascular disease as a means of reducing avoidable mortality and morbidity, we have established the Cardiovascular Disease (CVD) Risk Factor Programme, within the Preventative & Proactive Care Programme.

This programme of work will support efforts to improve the identification and management of key clinical risk factors (high blood pressure, hyperlipidaemia, raised HbA1C, and obesity) by improving public and community understanding of CV risk factors and transforming the models of care for detection and management these conditions.

The recognition of racialised health inequalities in regard to cardiovascular disease has informed work to date, and ongoing engagement with minority ethnic communities will ensure that their voices are centred in this work.

Perinatal care

The Best Start, published in January 2017 as a five-year forward plan for the improvement of maternity and neonatal services in Scotland, outlined a model of maternity services underpinned by continuity of carer for all women. This model brings additional care, advice and support around each individual woman and her family. In response to the data and evidence, we have prioritised roll-out of continuity of carer for women from Black and minority ethnic backgrounds, as well as for those experiencing multiple social complexity.

The Scottish Government established a Short-Life Working Group on racialised health inequalities in maternity care in January 2023 to focus on identifying and taking action to tackle these inequalities specifically. Co-Chaired by Maree Aldam, CEO of Amma Birth Companions, and Dr Alastair Campbell, consultant obstetrician and Royal College of Obstetricians and Gynaecologists (RCOG) lead for Scotland, the group brought together third sector organisations representing the views of service users and communities,

clinicians, midwives, professional bodies and national networks. Its purpose was to address racialised inequalities in maternity care and ensure the voices of those with lived experience are at the centre of our work to tackle those inequalities.

Following five meetings of the SLWG across 2023-2024, work continues to coproduce the group's outputs, which we anticipate will be complete by end Summer 0 4. These will be shared widely upon publication and will include further support and guidance for NHS Boards in understanding racialised inequalities in maternity and neonatal services. We are grateful to all members of the SLWG for their ongoing work, including colleagues working in maternity services across Scotland's N S Boards, and for their commitment to tackling racialised health inequalities and improving experiences and outcomes for women and families.

Mental Health

We published our new Mental Health and Wellbeing Strategy, jointly with COSLA, in June and Delivery Plan and Workforce Action Plan in November 2023. We worked closely with stakeholders, including minority ethnic groups, on our Equality and Human Rights Forum, to gather evidence and develop our Strategy and Delivery Plan and ensure it has equalities and human rights at its core. The Strategy sets out a vision of a Scotland, free from stigma and inequality, where everyone fulfils their right to achieve the best mental health and wellbeing possible. The evidence informing the Strategy has been published in the Scottish Government Mental Health Equality and Evidence Report.

The Delivery Plan lays out actions which are designed to make substantial progress towards this vision. It acknowledges that we must take an intersectional approach, recognising that people are multi-faceted. We need support, services, care and treatment that are person-centred, anti-racist, culturally sensitive, fully inclusive and in a range of formats. We will tackle mental health inequalities as highlighted in the Inequality Action Table in Appendix 1 of the Delivery Plan. Accessible supports and services that are sensitive to the needs of marginalised groups have been highlighted as a priority in evidence and by stakeholders. In this first Plan, we will focus attention on improving equality of access to and experience of mental health support and services with a specific focus on actions under Priority 4.

We have developed quality standards for adult secondary mental health and a service specification for Psychological Services and Therapies, as part of a suite of standards and specifications covering mental health services. These aim to improve the quality and safety of mental health services, improve the experiences and outcomes for people who use mental health secondary services and reduce unwarranted variation in the quality of care. The standards and specifications should ensure that services provide mental health care, treatment and support that is person-centred and free from discrimination or stigma, meeting the needs of all individuals, including those of minority ethnic people.

Prevention and early intervention are also a key focus of work to address minority ethnic health inequality. We have invested £51 million in the Communities Mental Health and Wellbeing Fund for adults since 2021 to help tackle the impact of social isolation, loneliness and mental health ine ualities faced by a range of 'at risk' groups including minority ethnic groups.

The Scottish Government has also commissioned national patient-level data to help with service planning and improvement, for measuring the true impact of investment, and for telling the stories of people seeking and receiving treatment in CAMHS and PT services. The current aggregate data collection for CAMHS and Psychological Therapies (PT) waiting times is adequate for reporting on the standards, but lacks more detailed information. Patient-level data will provide intelligence on protected equalities, reasons for referral, pathways followed, treating clinicians, diagnoses, treatments, and patient outcomes. Boards have been commissioned to upgrade data systems and IT systems to enable the recording and collection of this data.

Gypsy Traveller (G/T) Health

The G/T community experience some of the starkest health inequalities in Scotland. Action to improve their health is set out in the joint Scottish Government/CoSLA G/T Action Plan published in 2019. A new action plan will be published this year.

Community Health Workers (CHWs)

Introducing CHWs was a key health commitment in the 2019 Action Plan. The Scottish Government has funded the Minority Ethnic Carers of People Project (MECOPP) to deliver this action, the focus of which has been recruitment of a small number of CHWs, who are members of the G/T community.

The programme, which became operational in December 2021, has enabled bespoke services to be provided to G/T communities in Health Board areas based on the location of the CHWs recruited. A critical aspect of the role is using CHWs position within their own G/T community and their local relationships to improve access to healthcare, for example, by removing obstacles and building trust. The role and impact of CHWs has been widely welcomed and recognised as contributing to meeting many of the needs of the G/T community where the programme has been operational.

The Interim Evaluation (University of Dundee, 2022) and Final Evaluation Report, published in 2024, provide more detail on CHW impact.

The Scottish Government will continue to fund MECOPP CHWs and work with Public Heath Scotland, MECOPP and Health Boards to embed the learning in mainstream services. Whilst there is a strong focus on Health Boards with CHWs, SG and MECOPP will engage with all Boards to share learning and support improvement across the system. Consistent with feedback from the G/T communities, the following national priorities have been agreed:

- vaccination and immunisation, with a focus on children and young people;
- screening;
- long-term conditions e.g. cancer, diabetes;
- mental health, with a specific focus on suicide prevention amongst men; and
- primary care and community services including, specifically, access to General Practice and community pharmacy.

We have asked Health Boards with CHWs to agree local priorities, taking account of the above, develop a plan for mainstreaming best practice and share learning.

GP Registration - Blue card scheme
This scheme supports Gypsy Traveller (G/T) community members and others who need help to register with GP practices across Scotland. The first is a business card which sets an individual's rights to healthcare in Scotland. The second card is a larger, si sid ed 'Z card' which provides the information about the out of hours, as well as more detail including reference to the recently revised Charter of Patient Rights and Responsibilities and NHS 24.

For further information see https://www.healthliteracyplace.org.uk/toolkit/access-to-healthcare/

Public Health Scotland – Inclusive communication guidance
Public Health Scotland (PHS) commissioned the Place Standard Tool Inclusive Communication Toolkit. Inclusive communication includes as many people as possible in any communication and through any channel – in person, on the phone, online or on paper. Communication is a two-way process.

Tailoring public health messages to Gypsy/Travellers to reflect cultural realities which is a good practice guide is also available from PHS.

All public services in Scotland have a responsibility to reduce inequalities and help create society where everyone can thrive. PHS learning hub provides practice development, improvement support and testimonials aimed at supporting public services, to address the barriers that cause inequalities:

- Course: Making communication even better
- Course: Making services inclusive for all
- Course: Breaking barriers to reduce inequalities

- Tools and Resources to support the delivery of the public health role
- NHS Health Scotland National Information Resources
- eLearning and Evidence
- Further information

Annex 4 Approach to anguage and Abbreviations

Introduction

We recognise that across Scotland, people belonging to minority ethnic communities define themselves and their communities in different ways. As a result, it is unlikely that any single term will be suitable for all communities. Whenever possible, we will avoid using collective terms and composite categories that group various minority ethnic communities together, as this can overlook the unique identities and specific inequalities and needs of each group. We will always endeavour to be as specific as possible. We will also encourage the communities we work with to use their preferred language and we will adopt this language wherever possible in our communications.

As our understanding of race, ethnicity and racism grows, the Scottish Government (and others) are increasingly using terms such as 'adversely racialised', 'racially minoritised', 'racialised minorities', and 'racialisation'. The change in language recognises that racism is a systemic problem where systems and structures unequally advantage or disadvantage people and communities based on their perceived 'race'. The term 'racialisation' highlights the process by which people are categorised based on their 'race', with each category occupying a different position in the social hierarchy. The term 'minoritised' reflects that a group/community that is treated as a minority, often in unfair ways, even though they may not be a statistical minority in the global population. We use these terms interchangeably with the term 'minority ethnic group', depending on the context.

We will remain adaptable and refine our approach to language as our and society's understanding of race, ethnicity, racism, and health continues to develop. We welcome constructive challenge and feedback on our language and our wider work to address racialised healthcare inequalities through an anti-racism approach.

Overview of terms used in this guidance and key sources cited

Jump to…

- A-C
- D - G
- H – L
- M - P
- R
- S – Z
- Abbreviations

A – C

(*Back to top*)

Active Bystanders	People who try to do something to improve the situation. It involves being aware of inappropriate behaviour and challenging it or asking a third party to help. Being an Active Bystander does not mean you have to respond immediately, especially if you do not feel safe to do so. See Cultural Humility | Turas | Learn (nhs.scot) and the 5 Ds of Bystander Intervention
Ally	Someone who champions underrepresented groups whilst not being a member of the group that they are defending. There are various ways that you can demonstrate allyship. Source: (NHS Imperial College Trust). To find out more, visit the Leading to Change Being an Ally toolkit.
Anti-Racism	Anti-racism is a process of actively identifying and opposing racism, prejudice, discrimination, and systemic inequalities based on race. It is not just about not being racist, but actively taking a stand against racism and promoting equality for individuals of all racial and ethnic backgrounds. Anti-racism involves: • recognising and challenging our own biases, • educating ourselves about different cultures, • advocating for justice, • actively changing the policies, behaviours, and beliefs that perpetuate racist ideas and actions, • and actively working towards creating a more inclusive and equitable society. See Cultural humility e-learning, Fairer Scotland Anti-racist Employment Strategy and rofessor Kevin Fenton 'A public health approach to incorporating anti-racism in tackling racial and ethnic health disparities'.
BAME/BME	Black, Asian, and minority ethnic (BAME) / Black and minority ethnic (BME). In line with NHS Race and Health Observatory (NHS RHO) principles on writing and talking about race and ethnicity, we avoid the use of acronyms or initialisms to refer to groups of people. This is because acronyms can create a further level of distance from the communities we are talking about and can be perceived as dehumanising. The terms also have other limitations, e.g. homogenising diverse identities and backgrounds into an acronym can be problematic. See p. 5 and 6 of the NHS RHO Power of Language Report, Using the right words to address racial disparities in Covid-19

	and Anti-racism in Scotland Progress Review 2023, p.5, Advance HE Use of language: race and ethnicity, Queen Mary University of London – Short Guide to Understanding Race and Ethnicity Language and Terminology
Bias	A tendency to prefer someone or something more than another. It can also be prejudice against an individual or group in a way that is unfair or uninformed. See Cultural Humility | Turas | Learn (nhs.scot)
BPOC / BIPOC	Black and People of Colour / Black, Indigenous, and People of Colour are acronyms used in the UK and other parts of the world, especially in the United States, which acknowledge the distinct histories, cultures and struggles of Black, Indigenous and people of colour. Some organisations, such as Durham University, use it because the term avoids use of 'minority' when referring to people that belong to the global majority. See Oxford Review BIPOC – Definition and Explanation, Durham University's Guide on communicating inclusively about race and ethnicity.
Cultural Appropriateness	Being sensitive to people's cultural identity or heritage. It means being alert and responsive to beliefs or conventions that might be determined by cultural heritage (Care Quality Commission, 2022 cited in Cultural Humility | Turas | Learn (nhs.scot)).
Cultural Awareness / Sensitivity	The ability to perceive our own cultural beliefs, values, and customs, and to understand how they shape our decisions and behaviour. See Cultural Humility | Turas | Learn (nhs.scot)
Cultural Competence	An ongoing process of seeking cultural awareness, knowledge, skill and encounters in which we continuously strive to achieve an ability to effectively work within an individual's cultural context (Campinha-Bacote, J., 2002, cited in Cultural Humility | Turas | Learn (nhs.scot))
Cultural Humility	A concept and framework that goes beyond cultural awareness and sensitivity. It involves a deeper level of self-reflection, self-critique, and an ongoing willingness to learn and engage with individuals from different cultural backgrounds. Cultural humility acknowledges that nobody can ever fully understand or master every aspect of a culture, and it encourages a lifelong commitment to understanding and respecting others' experiences, values, and worldviews. See Cultural Humility | Turas | Learn (nhs.scot)

D – G

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Discrimination	Treating a person or group of people differently than you would treat other people because of their race, sex, disability, sexuality etc. See Cultural Humility | Turas | Learn (nhs.scot) and Race discrimination by Equality and Human Rights Commission
Equality and Equity	Equity refers to the way individuals are treated that is just and fair. Equality is defined as the state where everybody will be on the same level playing field. Equity is a process or procedure, whereas equality is the end result. The Equality Act 2010 provides a legal framework outlining duties to eliminate discrimination. See A Fairer Scotland for All: An Anti-racist employment strategy and Cultural Humility | Turas | Learn (nhs.scot)
Equality Impact Assessment (EQIA)	An Equality Impact Assessment (EQIA) provides a systematic way of considering how services, policies, projects, or programmes might affect people differently. The EQIA allows us to identify potential negative impacts on different groups in society. We can use it to adapt the way we work to prevent discrimination; and it also allows us to record and demonstrate these actions. See NHS Education for Scotland Introduction to Equality Impact Assessment (EQIA)
Ethnicity	Refers to the categorisation of people based on shared cultural traits such as language, religion, customs, traditions, and shared historical experiences. Ethnicity includes the social and cultural identity of a group and is not based on biological or physical characteristics. Individuals within an ethnic group often share a common heritage and sense of belonging. Universities Scotland refer to a 1983 House of Lords decision that suggests an ethnic group share features including cultural traditions, a common language and literature, geographical origin (even if distant), a shared history the group is conscious of. See Advance HE Use of language: race and ethnicity. 'Updated Guidance on the Reporting of Race and Ethnicity in edical and Science Journals', and Critically Appraising for Antiracism
Ethnic minority – see minority ethnic group(s)	This term is used in the UK to refer to all ethnic groups except the White British/Scottish group. It includes White minority groups.

	Often used interchangeably with 'minority ethnic group,' the latter emphasising the minority/minoritised status as opposed to ethnicity. (Short Guide to Understanding Race and Ethnicity Language and Terminology, Advance HE Use of language: race and ethnicity).
Global Majority	Global Majority is a collective term coined by Rosemary Campbell-Stephens MBE, that is increasingly used to refer to people who are Black, Asian, Brown, dual-heritage, indigenous to the global south, and/or have been racialised as 'ethnic minorities'. The term is considered more affirmative because it challenges marginalisation and minoritisation. See Global Majority: Decolonising the language and reframing the conversation about Race. Royal College of Midwives (RCM) Decolonising Midwifery education toolkit

H –

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Health Equity	This refers to the absence of unfair, avoidable, or remediable differences in health among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, ethnicity, disability, or sexual orientation). Health equity involves a commitment to reduce disparities in health and in its determinants. It emphasises the need to address the underlying social, economic, and environmental factors that contribute to health disparities and to provide resources and opportunities tailored to the needs of those who are disadvantaged. Health equity is achieved when everyone can attain their full potential for health and well-being. (A Strategic Framework to Tackling Ethnic Health Inequalities through an Anti-Racist approach)
Inclusion	Inclusion is the practice of including people in a way that is fair for all, values everyone's differences, and empowers and enables each person to be themselves and achieve their full potential and thrive at work. (Equality, diversity and inclusion (EDI) in the workplace)
Institutional Racism	See racism.
Intersectionality	The term 'intersectionality' has its roots in Black feminist activism and was originally coined by American critical legal race scholar Kimberlé Williams Crenshaw in 1989. Crenshaw used the term intersectionality to refer to the double discrimination of racism and sexism faced by Black women. The term recognises that people's lives are shaped by their identities, relationships and social factors, and that multiple forms of inequality and

	disadvantage compound to create complex obstacles, barriers and challenges that are often not understood. Intersectionality focuses on implications for the most marginalised within a group, seeking to understand how individual experiences within already marginalised and underrepresented groups differ, identifying and tackling hidden structural barriers. (Using intersectionality to understand structural inequality in Scotland: evidence synthesis; UN Women Intersectionality Resource Guide and Toolkit)
Islamophobia	Islamophobia is rooted in racism and is a type of racism that targets expressions of Muslimness or perceived Muslimness (All-Party Parliamentary Group, 2017)
Lived Experience	Refers to the firsthand knowledge and understanding that individuals gain from their personal life events and circumstances. This is different from theoretical or learned understanding. Lived experience provides wholesome valuable insights.[6] It is worth noting that it can be difficult and draining for people to share their experiences of racism and discrimination. Therefore, it is crucial to respect the boundaries of those who may be unwilling or reluctant to share their personal stories. Alternative methods, such as empathetic listening, creating safe spaces, and consulting documented accounts, should be employed to gain a comprehensive understanding of these experiences.

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Microaggression	This is an act or a remark, often indirect or subtle, that discriminates against one or more members of a minority group, either deliberately or by mistake. Examples of microaggression include making assumptions about people's abilities and preferences based on race or gender. ('Act Against Racism)
Minority Ethnic Group(s)	Scotland's 0 Census uses the term 'minority ethnic group' to encompass all racial and ethnic groups that are not classified within the majority White categories ('White Scottish' and 'White Other British'). The term therefore includes a diverse range of backgrounds, such as African, Caribbean or Black, Pakistani, Irish, Polish and Gypsy/Traveller. The census 2022 ethnic group analysis, is now available here.

[6] LIVED EXPERIENCE | English meaning - Cambridge Dictionary

	Some sources of research and evidence we draw on may use a different definition of 'minority ethnic group', e.g. one that excludes people from a minority White background. Where that is the case, we will ensure this is clarified in the text, or via a footnote. It is worth noting that minority ethnic communities have been minoritised through social processes of power and domination rather than existing as distinct statistical minorities. Also, minority ethnic communities are not a homogeneous group, in the same way that groups of people that share another protected characteristic (e.g. disability, sex, sexual orientation) have diverse identities, experiences and needs. Therefore, we endeavour to be as specific as possible, and will avoid using collective terms and composite categories where possible. See Scotland's Census 0 - Ethnic group, national identity, language and religion | Scotland's Census (scotlandscensus.gov.uk), Anti-Racism in Education Programme: factsheet - gov.scot (www.gov.scot), Advance HE Use of language: race and ethnicity.
Person-Centred Care	Person centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. See NHS Education for Scotland
Prejudice	A preconceived and unjustified negative judgment or attitude toward individuals or groups based on their perceived characteristics, such as race, ethnicity, or gender. See Cultural Humility | Turas | Learn (nhs.scot)
Protected Characteristics	One of nine personal characteristics or situations that cannot be used as a reason to discriminate against someone / treat them unfairly, according to discrimination law.[7] The protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. See Equality and Human Rights Commission
Public Sector Equality Duty (PSED)	The PSED is a legal requirement for public authorities, and organisations carrying out public functions, to have due regard to the need to: • put an end to unlawful behaviour that is banned by the Equality Act 2010, including discrimination, harassment and victimisation.

[7] PROTECTED CHARACTERISTIC - Cambridge English Dictionary

	• advance equal opportunities between people who have a protected characteristic and those who do not. • foster good relations between people who have a protected characteristic and those who do not. See The Public Sector Equality Duty (PSED), and Public Sector Equality Duty: specific duties in Scotland

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Race	Race is a social construct, used to categorise and group people based on physical characteristics such as skin colour, facial features, and hair texture. It is not based on any biological or genetic reality but rather on social perceptions and historical contexts.. Under the Equality Act 2010, the definition of 'race' includes colour, nationality, and ethnic or national origins. See Advance HE Use of language: race and ethnicity, Racialising genetic risk
Race and ethnicity	Race and ethnicity are social constructs; neither term describes fixed biological or genetic characteristics of a population[8]. However, the health consequences of living in a racially stratified society are illustrated by a myriad of health outcomes that systematically occur along racial and ethnic lines, such as disproportionately higher rates of infant mortality, obesity, deaths caused by heart disease and stroke, and an overall shorter life expectancy for Blacks in comparison with Whites.[9] The categories and terminology relating to race and ethnicity are dynamic and vary, depending on context and time; the terms are often used interchangeably (see definition of 'ethnicity' and 'race'). s a result, the ea lth and Care Race and thnicity at a Short-Life-Working Group are following updated international guidance by using the collective term 'race and ethnicity' to include subcategories of race and subcategories of ethnicity.[10] See 'Updated Guidance on the Reporting of Race and Ethnicity in edical and Science Journals', and Critically Appraising for Antiracism
Racism	Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks, that unfairly disadvantages some individuals and communities,

[8] Racialising genetic risk: assumptions, realities, and recommendations - The Lancet
[9] rofessor Kevin Fenton 'A public health approach to incorporating anti-racism in tackling racial and ethnic health disparities'
[10] Flanagin A, Frey T, Christiansen SL, AMA Manual of Style Committee. Updated Guidance on the Reporting of Race and Ethnicity in Medical and Science Journals. JAMA. 2021;326(7):621–627. doi:10.1001/jama.2021.13304

	unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources (Professor Camara Jones). Racism is considered a fundamental determinant of health as it influences behaviours, policies, practices, and pathways that influence health. Individuals subjected to racism and discrimination also experience higher rates of chronic stress, which further impacts health, as well as systemic biases and inequalities in healthcare. rofessor Kevin Fenton 'A public health approach to incorporating anti-racism in tackling racial and ethnic health disparities', rofessor ichael armot's 'Tackle discrimination, racism and their outcomes', Structural racism: what it is and how it works,
Racism – Institutional Racism	The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping, which disadvantage minority ethnic people. (Macpherson Report definition)
Racism – Systemic and Structural	These terms emphasise that racism is not always conscious, intentional, or explicit. Instead, these forms of racism are invisibly and deeply embedded in and throughout our systems and structures. Systemic racism emphasises the involvement of whole systems, such as political, legal, economic, healthcare, education, and criminal justice systems, as well as their structures. As such, the term systemic racism includes structural racism. Structural racism emphasises the role of structures, such as laws, policies, institutional practices, and entrenched norms. See e alth ffairs' Systemic And Structural Racism: Definitions, Examples, Health Damages, And Approaches To Dismantling; Racism and Health: Evidence and Needed Research; Call to Action: Structural racism as a fundamental driver of health disparities;
Racialisation	The process of categorising or dividing based on race, or superficial racial features, and ascribing meaning, qualities and value to those socially constructed racial categories. This process positions each racial category within a social hierarchy, influencing how individuals and groups are perceived and treated. The term highlights that race is a sociopolitical concept. See rofessor Kevin Fenton 'A public health approach to incorporating anti-racism in tackling racial and ethnic health

	disparities', the racialisation process (Oxford University Press) and The Canadian Encyclopaedia
Racialised Minority	A term used to reflect the process of placing people in set categories and who subsequently experience negative effects from being in a certain category because of the way different groups are assigned different identities as decided by society. Scottish Government is using the terms "adversely racialised communities", "racially minoritised/racialised minorities", and "racialisation" to show that it is systems and structures that do not work for those who are categorised based on "race", and because of this, are sometimes treated differently or disadvantaged. These terms are becoming more widely used across Scottish Government, in line with our acceptance that racism is a structural issue. We support everyone's' right to self-identify according to the term they relate to or are most comfortable with. Terminology changes as societal and systemic understanding grows. See Anti-racist employment strategy – A Fairer Scotland for All
Racially minoritised	The term recognises that people have been actively minoritised (made to feel as though they are a minority, in a way that is unfair[11]) and treated differently through social processes of power, rather than being a statistical minority. See Queen Mary University of London – Short Guide to Understanding Race and Ethnicity Language and Terminology

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Stereotypes	Oversimplified, generalised beliefs or assumptions about individuals or groups based on their perceived characteristics, often leading to biased judgments and expectations. See Cultural Humility | Turas | Learn (nhs.scot)
Structural Inequality	Structural inequality refers to a system where prevailing social institutions offer an unfair or prejudicial distinction between different segments of the population in specific society. See Anti-racist employment strategy – A Fairer Scotland for All
Structural Racism	The normalisation and legitimisation of an array of dynamics (historical, cultural, institutional, and interpersonal) that routinely advantages White people, while producing cumulative and chronic adverse outcomes for people of colour.

[11] MINORITIZE | definition in the Cambridge English Dictionary

	Structural racism concentrates power among privileged groups and devalues and limits opportunities for social, economic, and financial advancement which in turn results in a complex interplay between race, social determinants, and health. See rofessor Kevin Fenton's lecture A public health approach to incorporating anti-racism and structural discrimination in tackling racial and ethnic health disparities.
Unconscious Bias	Unconscious Bias is the way we have been socialised from the time we were born to have various mental models and mental short-cuts. We make judgements or decisions based on our influences, assumptions, and interpretations without knowing that we are relying on these subjective inputs. Unconscious bias also manifests itself in stereotypes; mental models of how we expect others to be or to behave.

Abbreviations
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APPG	All Party Parliamentary Group
AREP	Anti-Racism in Education Programme
BMA	British Medical Association
BMJ	British Medical Journal
CIPD	Chartered Institute of Personnel and Development
CRER	Coalition for Racial Equality and Rights
CVD	Cardiovascular Disease
EMF	Ethnic Minority Forum
EQIA	Equality Impact Assessment
ERG	Expert Reference Group on COVID-19 and Ethnicity
GCPH	Glasgow Centre for Population Health
GMC	General Medical Council
MECOPP	Minority Ethnic Carers of People Project
NNAP	National Neonatal Audit Programme
PfG	Programme for Government
PHS	Public Health Scotland
PMRT	Perinatal Mortality Review Tool
PSED	Public Sector Equalities Duty
RCM	Royal College of Midwives
RCN	Royal College of Nursing
REF	Race Equality Framework for Scotland 2016-2030

RHO	NHS Race and Health Observatory
SAER	Significant Adverse Event Reviews
SMR	Scottish Morbidity Records
SPSP	Scottish Patient Safety Programme
T2D	Type 2 Diabetes

Annex 5 Actionable insights and resources

Jump to…

- Developing an anti-racism plan / strategy
- Case examples – what have others done?
- Participation
- Workforce
- Improving race and ethnicity data and evidence
- Equity-focused service delivery
- Building understanding on anti-racism and related skills

Building understanding

The resources listed in the table below will help build understanding of racialised health inequalities and anti-racism approaches and practice.

Anyone working within health and care in Scotland, is also invited to join the Community of Practice on Anti-racism and Racialised Healthcare Inequalities. The community is an informal network whose aims are to:

- **Build understanding and promote awareness** of racialised health inequalities and the impact of racism on health and healthcare;
- **Share resources, good/emerging practice,** ideas, experiences and strategies to tackle racialised healthcare inequalities and racism;
- **Foster collaboration,** partnership working, and collective action;.
- **Inspire** members and our wider networks to take tangible steps towards racial equity.

For more information and to join, please email HealthEquity@gov.scot

Resources to build understanding	Published by
Watch	
A public health approach to incorporating anti-racism and structural discrimination in tackling racial and ethnic health disparities (GCPH lecture with Professor Kevin Fenton, Regional Director for London at Office for Health Improvement and Disparities, Public Health Advisor to the Mayor of London, President of the Faculty of Public Health)	Glasgow Centre for Population Health
Anti-Racism and Health: Levels of Intervention (Professor Camara Jones) – Acknowledging racism and its systemic nature is the first step for reform	King's College London (2022)

Anti-racism and Health (part 2): Tools for Confronting Racism Denial – using stories to communicate across divides (Professor Camara Jones)	King's College London (2023)
Critical appraisal for anti-racism webinar (recorded)	Healthcare Improvement Scotland
Understanding Racism	NHS Lothian
Risky bodies & risk assessments: melanin is not a risk factor	Dr Isioma Okolo
Listen	
Health inequalities associated with race	NHS Race and Health Observatory (2024)
Professor David Williams on racism, discrimination and the impact they have on health	The King's Fund podcast
Learn	
Anti-racism introductory resources (short films) covering definitions, discrimination and harassment, power and privilege and actions that can be taken. Available on Turas here.	NHS Education for Scotland (2024)
Anti-Racism Resources (scot.nhs.uk)	NHS Lothian
Resources **to improve collection and understanding of equalities data**. Resources include: Course: How to collect patient equality and needs data; Leaflets for patients and professionals Research findings	Public Health Scotland, 2024
Race | Turas | Learn (nhs.scot)	NHE Education for Scotland
Allyship Hub and toolkit	NHS Education for Scotland
Cultural humility e-learning on Turas	NHS Education Scotland
Equality and diversity zone on Turas	NHS Education Scotland
Introduction to Equality Impact Assessment (EQIA)	NHS Education Scotland
Critically appraising for anti-racism	University of Cambridge Medical Library
Read	
Racism and Health: A Public Health Crisis We Can Solve (Professor Kevin Fenton)	London Association of

	Directors of Public Health (2024)
The Lancet Series on racism, xenophobia, discrimination, and health	The Lancet (2022)
Racialising genetic risk: assumptions, realities, and recommendations	The Lancet (2022)
Advancing racial and ethnic equity in health	The Lancet (2022)
Excellence through equality: anti-racism as a quality improvement tool	NHS Confederation
Moving from not racist to anti-racist	The King's Fund (2024)
The enduring effects of racism on health: Understanding direct and indirect effects over time (Stopforth S, Kapadia D, Nazroo J, Bécares L.)	SSM Popul Health. 2022
Coalition for Racial Equality and Rights publications	Coalition for Racial Equality and Rights
NHS Race & Health Observatory publications	NHS Race and Health Observatory
Gypsy/Traveller resources	Minority Ethnic Carers of People Project (MECOPP)
Health Inequalities in the Gypsy, Roma and Traveller Community – How are we making change happen?	Public Health Scotland (2022)
Right to healthcare for people with no recourse to public funds	Public Health Scotland (2024)
Levels of Racism: theoretic framework and a gardener's tale	Professor Camara Jones
Global Majority: Decolonising the language and reframing the conversation about Race. Also see the Centre for Race, Education and Decoloniality	Leeds Beckett University, Carnegie School of Education

Developing an anti-racism plan / strategy

Resources	Published by
Developing an anti-racism strategy	CIPD (The Chartered Institute of Personnel and Development)
Excellence through equality: anti-racism as a quality improvement tool	NHS Confederation
Tackling racism in the workplace: guidance for employers. Resources and guidance to help mental health employer organisations and employees (UK)	Royal College of Psychiatrists (2023)
Tackling racism in the workplace maturity matrix	Royal College of Psychiatrists (2023)
Act boldly – anti-racist principles, guidance and toolkit	Wellcome (2021)

Examples of what have others done

Resources	Published by
NHS Grampian anti-racism plan launch (anti-racism video statement)	NHS Grampian
NHS Grampian Anti-racism Plan 2023 - 2028	NHS Grampian
N S rampian's ' t's ok to talk about race' video	NHS Grampian
Becoming an anti-racist health board –	NHS Grampian
(Community of Practice recording) NHS Grampian: from Zero-Tolerance to Anti-Racism	PHS for Community of Practice to address racialised inequalities in H&SC
NHS Lothian commitment to being anti-racist and published commitments	NHS Lothian
Anti-Racism Resources (scot.nhs.uk)	NHS Lothian
A Strategic Framework to Tackling Ethnic Health Inequalities through an Anti-Racist Approach	Transformation Partners in Health and Care with OHID
Wellcome Anti-racist principles, guidance and toolkit	Wellcome Trust
Excellence through equality: anti-racism as a quality improvement tool	NHS Confederation
East of England Race Strategy 2021 – Making anti-racism a reality	NHS England and NHS Improvement
North West Black, Asian and Minority Ethnic Assembly Anti-racist Framework	NHS England North West

Participation

Resources	Published by
Health and social care – Planning with People: community engagement and participation guidance – updated 2024	Scottish Government (2024)
Participation Toolkit	Healthcare Improvement Scotland
Participation handbook	Scottish Government (2024)
Paying participant expenses and compensating time: guidance	Scottish Government (2024)
Engaging people and communities: step by step	Healthcare Improvement Scotland
Co-production (to note – co-production goes beyond participation and partnership working – it requires people to work together on an *equal* basis)	Scottish Co-production Network

Workforce

Resources	Published by
Bullying and harassment support	Royal College of Nursing
Experiences from health and social care: the treatment of lower-paid ethnic minority workers (2022)	Equality and Human Rights Commission
Fair to refer report – reducing disproportionality in fitness to practice concerns reported to the GMC (2019)	General Medical Council
Anti-Racism Resources (scot.nhs.uk)	NHS Lothian
Guidance for employers on taking an anti-racist approach to tackling women's workplace ine uality	Close the Gap (2022)
Tackling racism in the workplace: guidance for employers. Resources and guidance to help mental health employer organisations and employees	Royal College of Psychiatrists (2023)
Tackling racism in the workplace maturity matrix	Royal College of Psychiatrists (2023)
On leadership that leads to racial justice	The King' Fund (2021)

Improving race and ethnicity data and evidence

Resource	Published by
Resources to improve collection and understanding of equalities data. Resources include: Course: How to collect patient equality and needs data; Leaflets for patients and professionals Research findings	Public Health Scotland, 2024
Scotland's Census 0 – Ethnic group, national identity, language and religion	Scotland Census, 2024
Monitoring racialised health inequalities in Scotland – 30 May 2023	Public Health Scotland, 2023
What is Discovery? - Overview - Discovery - Services - Public Health Scotland Online management information system	Public Health Scotland
Scottish Morbidity Records (SMR): ethnic group recording data files	Public Health Scotland
How we can make better use of ethnicity data to improve healthcare services	BMJ, 2023
A guide for NHS leaders and policy makers on closing the gaps in patient data for Black & South Asian communities (specifically the section on how to reduce the risk of causing harm, pages 12 – 15)	Understanding Patient Data, 2022
A guide for healthcare workers – closing the gap in patient data for Black and South Asian communities	Understanding Patient Data, 2022
The dividing line: how we represent race in data	Open data institute (2020)

Equity-focused service delivery

Resource	Published by
General insights	
Ethnic Inequalities in Healthcare: A Rapid Evidence Review	NHS Race and Health Observatory (2022)
Racialising genetic risk: assumptions, realities, and recommendations	The Lancet (2022)
NHS Race & Health Observatory Research and Publications	NHS Race and Health Observatory
Mental Health	
Mental Health and Wellbeing Delivery Plan 2023 - 2025	Scottish Government and COSLA (2023)
Mental Health and Wellbeing Strategy	Scottish Government and COSLA (2023)
Racial Inequality and Mental Health in Scotland – a call to action (recommendations to Health Boards on p. 13)	Mental Welfare Commission for Scotland (2021)
Inequalities in Mental Health Care for Gypsy, Roma, and Traveller Communities, Identifying Best Practice (Recommendations for practice on p.13 and 55)	NHS Race and Health Observatory (2023)
Mental Health and Wellbeing of Black and Minority Ethnic Children and Young People in Glasgow (Includes key issues/challenges and recommendations)	Glasgow City HSCP (2022)
Mental Health Briefing Paper	Race Equality Foundation (2022)
Type 2 diabetes and cardiovascular disease prevention	
Ethnic disparities in quality of diabetes care in Scotland: A national cohort study (Study relating to racialised inequities in the quality of diabetes care in Scotland)	Scottish Diabetes Research Network epidemiology group (2024)
A Healthier Future – Framework for the Prevention, Early Detection and Early Intervention of type 2 diabetes	Scottish Government (2018)
Addressing Structural Racism Through Public Policy Advocacy: A Policy Statement from the American Heart Association.	American Heart Association (2024)

Perinatal care	
Birth Outcomes & p eriences Report (Scotland. The report shares e periences of often multi marginalised women supported by mma Birth Companions.)	mma Birth Companions (0 4)
SPSP Perinatal Webinar: Racialised Health Inequalities in Perinatal Services	ea lth mprovement Scotland, Scottish atient Safety rogramme (S S), ugust 0 4
Listen to u ms: nding the ostcode Lottery on erinatal Care (The report shares evidence on importance of access to interpreting services. See chapter 7 for experiences of birth trauma on marginalised groups, noting most significant variations in maternal outcomes relate to ethnicity and deprivation and the impact of racism.)	ll arty arliamentary ro up ( ) o n Birth Trauma (0 4)
S S erinatal Change ackage (ncludes resources to support uality improvement activity, including tackling racialised health ine ualities recommended for adoption and use by N S B oards).	ea lthcare mprovement Scotland and Scottish atient Safety (0 3)
erinatal Confidential n uiry: comparison of the care of sian and white women who have e p erienced a stillbirth or neonatal death and comparison of the care of Black and white women who have e p erienced a stillbirth or neonatal death (Stresses importance of linguistically appropriate services and information, follow-up non-attendance appointments, review and consider local data to identify, understand and respond to inequalities in outcome, esp. intersection of deprivation and ethnicity.)	BRR C UK (0 3)
Saving Lives, mproving o thers' Care 0 9 (Stresses importance of using local data to understand local demography and inform service planning).	BRR C UK (0 3)
The College's ambition for race e uality and Workplace Behaviour Toolkit (0)	Royal College of Obstetricians and yn aecologists (RCO)
National Neonatal udit rogramme Summary report on 0 data (Importance of ensuring design and delivery of care includes parents with diverse backgrounds)	National Neonatal udit rogramme (NN) (0 3)
Review of Neonatal ssessment and ractice in Black, sian and i nority thnic Newborns: ploring the pgar Score, the et ection of Cyanosis, and Jaundice	N S Race and e alth Observatory (0 3)

(Information concerning poor visual detections of jaundice, cyanosis and pallor in babies with darker skin tones. Need for anti-racism practice and cultural safety training).	
Learning from the e p eriences of Black and sian bereaved parents (Stresses importance of service user feedback and complaints to identify and act on inequalities, and the need for sensitive and tailored conversations about risk markers connected to ethnicity)	The Sands Listening roject, sands.org.uk (0 3)
Systemic racism, not broken bodies: n in uiry into racial injustice and human rights in UK maternity care (includes calls to action and actionable suggestions for change, with many applicable at local level)	Birthrights (0)
Continuity of carer and local delivery of care: implementation framework (Scotland) (NHS Boards expected to prioritise roll-out of continuity of carer to women from Black and minority ethnic backgrounds and those experiencing multiple social complexity.)	Scottish o vernment (0 0)
South sian families' e p eriences of neonatal care Recommendations for neonatal service providers on p. 5	Bliss for babies born premature or sick
Births in Scotland – nnual statistics reflecting a range of aspects of perinatal care, with breakdowns by N S Board and ethnicity	ublic e alth Scotland

Annex 6 Checklists and reflection prompts to support planning

The checklists and reflection prompts can help to:

- **Periodically track progress** of anti-racism plan development/refinement;
- **Encourage open and ongoing dialogue**, including engagement with diverse voices and perspectives;
- **Help identify adjustments** needed, thereby ensuring the plan remains a living document and a priority;
- Help **identify specific next steps** in the planning process, and identify **gaps and areas of concern**.

Checklists and reflection prompts have been provided for each area of focus in the framework for action:

- Development of your action plan
- Leadership and accountability
- Data and evidence
- Workforce
- Equity-focused service delivery

Development of your anti-racism plan

Meaningful participation	
Are you ensuring development of your plans is informed by people who have experienced racism and by those who have insights into how racism operates? (Your staff network may be able to support you to consider how to do this without asking contributors to relive traumatic experiences).	
Have you agreed how you will involve minority ethnic staff and communities in the scrutiny and review process?	
Content and process – ave you agreed…?	
The **strategic priorities** for your organisation (aligned to framework for action areas of focus)?	
The **outcomes** you are seeking to achieve?	
Indicators you will use to measure progress?	
How the plan will be updated, reported on and scrutinised?	
Alignment – Does your plan align with the focus areas in the framework for action?	
Workforce (You may wish to complete the 'workforce' checklist for a more detailed assessment)	
Equity-focused service delivery (You may wish to complete the 'e uity-focused service delivery' checklist for a more detailed assessment)	
Data and evidence (You may wish to complete the 'data and evidence' checklist for a more detailed assessment)	
Leadership & accountability (You may wish to complete the 'data and evidence' checklist for a more detailed assessment)	

e adership and accountability

Governance Do you have clear governance arrangements and lines of responsibility for the delivery of your strategic aims?	
Are Board-level discussion and scrutiny of progress on anti-racism action effective?	
Commitment Has the senior leadership considered a public commitment to being an anti-racism organisation?	
Have you got a plan to engage staff and enable a collective effort on tackling racism?	

Reflection prompts for leaders

❶ What steps are you taking to understand how racism is operating in your setting/area of responsibility through policies, practices, norms and values?

❷ What examples of racialised inequality have you identified in the areas where you hold power/influence? How are you planning to address the inequality?

❸ How are you diversifying decision-making spaces, including at Board level?

Data and evidence

Confidence & Understanding Are you taking steps to improve staff and patient understanding of why race and ethnicity data is collected, and how it is used?	
Board level data Have you considered and discussed the quality (accuracy and completeness) of race and ethnicity data collected by your Board, identified gaps, and agreed actions needed to improve it?	
Do you have a process in place for bringing together data and wider evidence to understand the racialised inequity experience by your workforce and minority ethnic communities in your area?	
Are you sharing the findings of analysis and actions to address inequality with staff to increase awareness of the impact of data collection?	
Evaluation Do you have a mechanism in place to bring together data, service and equality leads to develop a monitoring and evaluation framework for the anti-racism plan?	

Reflection prompts for leaders

❶ How confident and comfortable are staff to request and share race and ethnicity information?

❷ What would help you create a culture where staff and patients feel confident and comfortable to share their data?

❸ What steps are you taking to improve the accuracy and completeness of race and ethnicity data?

Workforce

Staff networks	
Do you have an active staff network focussed on race/ethnicity?	
Do staff have protected time to participate?	
Do you have effective mechanisms in place to ensure issues from networks are fed into senior leadership?	
Incident reporting	
Have you assessed and evaluated the effectiveness and person-centredness of your routes for reporting incidents of racism and discrimination?	
What specialist support is available to staff dealing with discrimination? Is this support clearly signposted?	
Are those investigating incidences of discrimination suitably trained in understanding the impact of racism?	
Talent pipeline	
Do you understand the barriers relating to recruitment, retention and progression for talent from minority ethnic groups?	
Do you have a plan / mechanisms to increase workforce diversity at senior and executive levels?	

Reflection prompts for leaders

❶ How do you monitor incidents relating to racism/discrimination, and the effectiveness and person-centredness of reporting mechanisms?

❷ How do you ensure your talent pipeline is equitable for people from minority ethnic and marginalised backgrounds?

❸ How many senior leaders are active allies? What support do they need to be confident and effective in their role?

Equity focused service delivery

Questions applying to all service delivery areas	
Do you promote the use of PHS equalities data resources to improve race & ethnicity data recording in core datasets?	
Do you understand the demography of your local population?	
Do you have a process in place to ensure early and meaningful completion of equality impact assessments to inform development and delivery of services and decisions?	
Are equality impact assessments living documents that are regularly reviewed and updated?	
Have you got effective mechanisms in pace to enable collaboration with staff networks, the third sector, community and faith groups?	
Do you use patient feedback/complaints to inform improvements relating to service planning and design?	
Specific questions on T2D and CVD prevention	
Do you understand inequalities in the receipt of care for your Health Board, e.g. in HbAiC monitoring?	
Are you promoting and using the PHS equalities data resources to improve race and ethnicity data on the weight management T2D prevention core dataset?	
Specific questions on Perinatal care	
Have you got active maternity engagement groups in your Board area?	
Are you taking a proactive approach to gaining feedback, particularly from minority ethnic and seldom heard communities, to identify opportunities for learning and improvement?	
Are you making use of the support packages offered through participation in the SPSP Perinatal Programme?	
Specific questions on Mental Health	
Are you taking a proactive approach to gaining feedback from minority ethnic communities concerning the quality of care and treatment provided to inform improvement work?	
Do you understand the barriers to access to mental health services and support for minority ethnic communities in your area?	

Reflection prompts for leaders

❶ How do you identify and understand any variation in quality and experience of services/treatment, particularly for underrepresented and seldom heard communities?

❷ How do you ensure feedback and complaints mechanisms are accessible and person-centred?

❸ How have you meaningfully and respectfully involved minority ethnic staff networks and communities in improvement work?

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Appendix 3

NHS Forth Valley Equality Impact Assessment (EQIA)

Please complete electronically and answer all questions unless instructed otherwise. Once complete please email to FV.EQIA@nhs.scot and we will be in touch shortly.

Section A – What's being assessed?

1. Title of EQIA being completed i.e., name of policy, project etc.
NHS Forth Valley Anti-Racism Plan

2. What is it? Please select the primary function.		
☐ Guidance	☐ Policy	☐ Project
☐ Protocol	☐ Service Change	☒ Strategy
☐ Other, please detail below…		

3. What is the purpose or objective(s) of the proposed work? Tell us about the main aim(s) of the work and the intended outcome(s).

Purpose:
The purpose of the NHS Forth Valley Anti-Racism Plan is to set out a clear, strategic and sustained approach to identifying, challenging and addressing racism across the organisation's workforce, services and systems.

The Plan builds on existing organisational commitments, including:

- NHS Forth Valley Population Health and Care Strategy (2025 to 2035)
- Equality and Inclusion Strategic Framework (2025-2029) - *for which it is one of our Equality Outcomes*
- Culture Change and Compassionate Leadership Programme
- Workforce Wellbeing Framework (2025 to 2029)
- Values-Based Health and Care Strategy

It also responds to national direction and expectations for NHS Boards to take proactive action to address structural and institutional racism, aligning with:

- Equality Act (2010)
- Equality Act (Specific Duties) (Scotland) Regulations 2012
- Fairer Scotland Duty
- Scottish Government's Anti-Racism Framework for Health and Social Care

Aims:

1. Ensure Visible Leadership and Shared Accountability at All Levels - strengthen accountability, transparency and trust with staff, patients and communities, with our senior leaders championing this and supporting participation.
2. Strengthen Workforce Experience and Wellbeing - improve the experience, safety, development and progression of colleagues from minority ethnic backgrounds.
3. Deliver Equitable, Culturally Competent Services - reduce racialised inequalities in health outcomes and access to services.
4. Empower Communities and Partnerships – build upon effective collaboration, partnership working and co-creation.
5. Use Data and Evidence to Drive Improvement – ensure an informed approach to change that utilises data and applies an effective learning system.
6. Learn, Reflect, and Share – highlight good practice, celebrate success and ensure a continual cycle of reflection and improvement.

Intended Outcomes:

A more equitable, inclusive and culturally competent organisation where racism is actively challenged and where colleagues and patients from minority ethnic backgrounds feel safe, respected, included and supported. Data will support the journey of improvement and continuous learning.

Governance and Monitoring:

- Oversight by a multidisciplinary dedicated working group reporting to the Strategic Workforce Programme Board.
- Formal reporting to Staff Governance and Clinical Governance Committees as per governance schedule.
- Use of workforce and service data to track disparities and evidence improvement.
- Qualitative feedback from staff networks, patients and communities.
- Publication of progress through equality reporting routes.

This EQIA will be reviewed regularly as part of the Anti-Racism Plan Working Group and updated to reflect any significant changes that are made to the scope or actions of the Plan.

4. Who will be affected by the proposed work? Please select all that apply.		
☒ Colleagues	☒ Patients / Service Users	☒ Family, Friends, Carers
☒ External Stakeholders	☒ Students	☒ Organisation
☐ Other, please specify below…		

5. What is the scope of the proposed work?		
☒ NHS Forth Valley/Health and Social Care Partnership Wide	☐ Service / Team Specific	☐ Discipline / Role Specific
☐ Other, please specify below…		

Section B – how have you involved people?

1. Tell us about how you involved people in the development of your proposed work? *For example, if you are telling us about a project to change staff working patterns, how have you engaged with colleagues? Did you consult anyone else that may be affected by the change? If you didn't involve people, tell us why. Did you use other evidence / data instead?*
Development of our Anti-Racism Plan has been informed by a combination of direct engagement, lived experience insight, workforce and service data, and national evidence. This approach ensures the Plan is grounded in real experiences and shaped by those most affected by racial inequality. Engagement Methods: • Ethnic Diversity Staff Network – provided lived experience insights and co-designed priorities for action. • Culture Change and Compassionate Leadership sessions – highlighted themes of psychological safety, inclusive leadership, and accountability. • Staff Engagement Surveys and Feedback (for plan and from wider work such as Workforce Wellbeing Framework engagement) – identified barriers to reporting racism and gaps in cultural competence. • Targeted Outreach – engagement with minority ethnic colleagues and community representatives through informal discussions and equality events. • National Learning – incorporated evidence from NHS Scotland equality networks, Public Health Scotland, and Scottish Government anti-racism programmes. Evidence Sources: • Workforce data (including lack of ethnicity reporting on eESS, disparities in terms of grievances and people processes and diversity within leadership roles) • Service data and national research highlighting racialised health inequalities in maternity, mental health, and long-term conditions. Key Themes Identified:

- Experiences of racism, microaggressions, and stereotyping in both workplace and care settings.
- Lack of confidence in reporting processes and fear of negative consequences.
- Need for visible leadership commitment
- Access to culturally competent care.
- Importance of psychological safety and trauma-informed support.

How Feedback Shaped the Plan:

- Strengthened leadership accountability and governance arrangements.
- Embedded lived experience into ongoing review and improvement.
- Improved data driven approach from internal and external sources
- Shifted from one-off awareness sessions to sustained, measurable actions.
- Prioritised culturally responsive wellbeing support and fair processes.

Commitment to Ongoing Engagement: The Plan is a living document. Engagement will continue through:

- Staff networks and equality partners.
- Community organisations and third-sector groups.
- Governance committtes
- Regular feedback loops to inform continuous improvement.

2. Provide a summary of your findings.
Include an overview of feedback received and / or any evidence used to develop your work. Using the example given above in question 1, if working on a project about staff working patterns, what feedback did staff provide? What was the feedback you received?

Engagement and evidence consistently highlighted that racism, both direct and indirect, continues to impact staff experience, wellbeing, progression, patient experience and psychological safety within healthcare settings. This is especially true for microaggressions, where there is often not the evidence threshold to report but are more likely to have a continued and increasing impact.

Key themes identified included:

- experiences of racism, microaggressions and racial stereotyping
- lack of confidence in reporting processes and fear of negative consequences
- inconsistent understanding of racism and anti-racism
- unequal experiences of recruitment, progression and disciplinary processes
- the need for visible leadership commitment and accountability

Evidence also highlighted the impact of racism on patient experience and outcomes, particularly for minority ethnic communities who may experience barriers to access, trust and culturally responsive care.

These findings reinforced the need for a coordinated, organisation-wide Anti-Racism Plan focused on systemic change rather than isolated actions.

3. Did you make any changes to your proposed work as a result of this feedback or evidence?
Think about people's different needs, potential barriers or challenges and how you might overcome these. Tell us about ways in which you've made sure your proposed work is inclusive and considers our diverse communities.

For example, using the same as above regarding staff working patterns, did any of the feedback influence the proposal, i.e. if staff said they wanted the option of shorter, frequent breaks as opposed to one long break within the working day, was this taken into account? If yes, in which ways, if no, then why not?

Yes.

Feedback and evidence directly informed the focus, priorities and structure of our Anti-Racism Plan. In response, the Plan:

- places a stronger emphasis on leadership accountability and governance
- prioritises psychological safety and culturally responsive wellbeing support
- strengthens commitments around fair and transparent processes
- embeds lived experience insight into ongoing review and improvement
- moves away from one-off awareness activity towards sustained, measurable action

- looks at ways in which we can tackle health inequalities, including ensuring targeted support for minority ethnic patients and service users to provide feedback.

The Plan also recognises the importance of intersectionality and avoids a one-size-fits-all approach, acknowledging that experiences of racism can be compounded by other protected characteristics or socio-economic disadvantage.

This ensures our Anti-Racism Plan is grounded in real experience, evidence-informed, and focused on meaningful and lasting change.

Section C – what's the impact of your work?

When looking at the impact of our work on equality groups, the Equality Act 2010 asks us to consider how our work will help to:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between different groups;
- Foster good relations between different groups.

This doesn't need to be complicated. With your work in mind, consider the ways in which it may have a positive, negative or neutral impact on different groups. For example:

- **Positive** – does your work reduce discrimination or stigma, promote participation and involvement, improve access or increase tolerance?
- **Neutral** – does your work have no impact on this specific group
- **Negative** – although it may be unintentional, does your work discriminate against particular groups, add barriers to access or put people at a disadvantage / make their lives worse?

Please refer to NHS FV EQIA Checklist for further support and guidance.

Groups	Positive	Neutral	Negative	Comments (please do not leave blank)
People of different Ages	☑			The Plan applies across all age groups. Indirect positive workforce impacts include improved organisational culture, psychological safety, and fair processes for everyone. Younger staff may benefit most from clearer reporting routes and inclusive leadership, reducing barriers to progression. Older staff may experience improved cultural competence and reduced bias in disciplinary processes. Direct positive impacts will include for older, minority ethnic adults as we know from evidence that they are among the most deprived and excluded groups in society, with poorer health outcomes, access to health and a lack of research or targeted outreach. Part of the work of this Plan will ensure focussed efforts to support generational inequalities, including

Groups	Positive	Neutral	Negative	Comments (please do not leave blank)
				ensuring improved access to Interpretation and Translation, alternatives to digitally-reliant resources and mechanisms to support sharing of feedback to help inform education and awareness for colleagues around the needs of this particular group of people. Example: Anti-racism training will help managers challenge age-related stereotypes that intersect with race (e.g., assumptions about language skills or tech ability).
People with a Disability		☑		Intersectionality is key: disabled colleagues and patients from minority ethnic backgrounds often face compounded barriers. Actions such as trauma-informed practice, culturally competent care, and improved data capture will support equitable access and workplace adjustments. Example: A disabled staff member from a minority ethnic background may benefit from fairer recruitment processes and culturally sensitive wellbeing support.
Trans and Non-Binary People		☑		While not gender-identity specific, the Plan supports wider inclusion commitments. Intersectionality matters: a trans person from a minority ethnic background may face compounded discrimination. Furthermore, evidence and engagement feedback shows that there can often be additional cultural barriers and sensitives to having a trans identity as a minority ethic individual. Anti-racism training and inclusive leadership will help mitigate this in addition to ensuring a safer and more inclusive culture for trans people from racially minoritised groups through education and targeted outreach

Groups	Positive	Neutral	Negative	Comments (please do not leave blank)
				and support. Example: Ensuring reporting systems are psychologically safe for all identities, including those who experience racism and transphobia and targeted outreach such as via Stirling Pride and cross-network collaborations for our workforce.
People who are Pregnant or on Maternity Leave	☑			Evidence consistently shows that women from minority ethnic backgrounds experience poorer outcomes and disparities in maternity care, including higher rates of adverse outcomes, barriers to access, and experiences of bias or discrimination. The Anti-Racism Plan is expected to contribute positively by strengthening organisational understanding of racialised inequalities, promoting culturally competent care, and supporting more equitable service design and decision-making. Examples: For patients, culturally competent maternity care pathways and improved interpretation services. For staff, fair return-to-work policies and bias awareness in performance reviews. Intersectionality: Minority ethnic women may also experience socio-economic disadvantage, compounding barriers to care and progression.
People who are Married or in a Civil Partnership		☑		The Plan does not impact marital or civil partnership status. No differential impact has been identified.
People from different Ethnic Backgrounds	☑			The Plan is specifically designed to address systemic and institutional racism and the disproportionate negative impacts experienced

Groups	Positive	Neutral	Negative	Comments (please do not leave blank)
				by colleagues, patients and communities from minority ethnic backgrounds. Actions are targeted, evidence-based and informed by lived experience, with a focus on improving safety, wellbeing, progression, trust and access to services. This constitutes lawful positive action under the Equality Act (2010) and is proportionate to the level of disadvantage identified through engagement and evidence. Examples: Workforce, targeted support for international and overseas colleagues, mentoring schemes, and anti-racism training. Services, co-designed care pathways for diabetes, maternity, and mental health. Intersectionality, Recognise compounded disadvantage for minority ethnic women, disabled people, and LGBTQ+ colleagues.
People with Religious or Protected Beliefs	☑			The Plan may have indirect positive impacts where experiences of racism intersect with religion or belief. Actions promoting cultural competence, psychological safety and fair treatment may improve experiences for individuals affected by racialised discrimination linked to faith or belief. Examples: Training includes awareness of racialised Islamophobia and anti-Semitism. Service design considers dietary requirements and prayer spaces. Intersectionality, Race and religion often overlap, so actions will address both.
Men and / or Women	☑			The Anti-Racism Plan is not gender-specific; however, evidence highlights that women from minority ethnic backgrounds often experience compounded disadvantage due to the

Groups	Positive	Neutral	Negative	Comments (please do not leave blank)
				intersection of race and gender. This can include stereotyping, differential treatment, barriers to progression, and unequal experiences in healthcare settings. By addressing racism, bias and structural inequality, the Plan is expected to have a positive indirect impact on minority ethnic women, both as staff and as patients, while contributing to fairer and more inclusive systems overall. Examples: Workforce, targeted leadership development for minority ethnic women and cross collaboration between staff networks. Services, addressing racialised disparities in maternity care.
A person's sexual orientation		☑		The Anti-Racism Plan does not directly impact sexual orientation. No adverse impacts are anticipated, and intersectional experiences will be considered where appropriate. Example: A minority ethnic LGBTQ+ person may face compounded discrimination; inclusive reporting and psychological safety measures will help mitigate this.
People who work with us	☑			The Anti-Racism Plan is expected to have a positive impact on the workforce by improving fairness, consistency and transparency across organisational processes. For colleagues from minority ethnic backgrounds, anticipated benefits include improved confidence in reporting concerns, clearer accountability, fairer access to opportunities, and greater trust in organisational systems and response to discrimination and racism.

Groups	Positive	Neutral	Negative	Comments (please do not leave blank)
				More broadly, our Plan supports inclusive leadership, improved understanding of bias and racism, and a workplace culture where dignity, respect and equitable treatment are actively promoted as we live our NHS Scotland values. Examples: Anti-racism training for all staff that includes unconscious bias and active bystander. Safe reporting mechanisms with trauma-informed support. Mentoring and career development programmes with targeted promotion and support to participate for minority ethnic colleagues.
People who are Carers or Care Experienced		☑		The Plan does not specifically target carers or care-experienced individuals. No differential impact has been identified; however, inclusive workplace practices may provide indirect benefit. Example: Minority ethnic carers may benefit from culturally competent wellbeing support and flexible working policies. Furthermore, ensuring appropriate Interpretation and Translation at all times will reduce the burden on minority ethnic care givers to bridge this gap.
People who are socio-economically disadvantaged	☑			Racism and socio-economic disadvantage often intersect. The Plan's focus on equity, access and fair processes may contribute to indirect positive impacts for individuals experiencing both racialised and socio-economic disadvantage. Example: Targeted financial wellbeing support that considers additional challenges for minority ethnic colleagues.
People living in poverty	☑			While the Anti-Racism Plan does not directly address poverty, actions relating to fair recruitment, progression, retention and access

Groups	Positive	Neutral	Negative	Comments (please do not leave blank)
				to services may contribute to indirect positive impacts by reducing barriers that disproportionately affect racialised groups experiencing financial hardship. Example: Improved interpretation services and culturally competent care can reduce missed appointments and associated costs for patients in poverty.
Other, please state… (i.e. Homeless or no fixed abode individuals, Veterans etc.)	☑			Refugees, asylum seekers and individuals with insecure immigration status may face significant racialised barriers when accessing healthcare, employment and support services. These can include language barriers, lack of trust in public services, fear of discrimination, and limited access to appropriate information or interpretation. The Anti-Racism Plan is expected to contribute positively by promoting culturally responsive practice, improving awareness of racialised disadvantage, and strengthening inclusive approaches to communication, interpretation and support. These actions may improve access, experience and outcomes for affected patients, communities and staff, while supporting more equitable service delivery across NHS Forth Valley. Example: Partnerships with third-sector organisations to build trust and co-design services for refugees and asylum seekers.

Having considered the various groups above, what's the overall difference / impact your work will make?
The Anti-Racism Plan is expected to make an overall positive and meaningful difference across NHS Forth Valley. It represents a proportionate, evidence-based

response to known inequalities and aligns with our legal duties under the Equality Act (2010), the Public Sector Equality Duty, and the Fairer Scotland Duty.

By implementing this Plan, NHS Forth Valley will:

- Eliminate Barriers and Discrimination
  Embed anti-racism principles within leadership, governance, and service design to challenge systemic and institutional racism, ensuring fair treatment for all.
- Advance Equality of Opportunity
  Improve access, experience, and outcomes for minority ethnic colleagues and communities through fair recruitment, progression, and culturally competent person-centred care pathways.
- Foster Good Relations
  Promote understanding, psychological safety, and inclusive leadership, creating a culture where diversity is valued and discrimination is actively challenged.
- Address Intersectionality
  Recognise and respond to compounded disadvantage (e.g., race and gender in maternity care, race and disability in service access) to avoid one-size-fits-all solutions and apply a person-centred and values-based approach.
- Build Trust and Transparency
  Strengthen confidence in reporting processes, improve accountability, and ensure progress is visible through regular governance reporting and public equality updates.

Overall Impact:
The Plan will help create a more equitable, inclusive, and culturally competent organisation where racism is actively identified, challenged, and staff and patients from minority ethnic backgrounds feel safe, respected, and supported. Indirect benefits will also be realised across other protected characteristics through improved organisational culture, psychological safety, and fairer systems.

Section D – does your work impact children?

The United Nations Convention on the Rights of the Child (UNCRC) is an international human rights treaty that grants all children and young people a comprehensive set of rights. Examples of these rights include the right to health and education, fair and equal treatment, protection from exploitation and the right to a voice in decisions that affect them. In Scotland, as of 2024 we have a duty to

consider how our work will impact children and young people. Further information can be found here: https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

Having considered the various UNCRC Rights, what's the overall difference / impact your work will make? Thinking about this will help you to complete the table below. It may be that not all of the UNCRC Rights are applicable.

It's important to remember that although not directly affecting, a service or project may have an impact on the life of a child or young person. For example, if it impacts upon a parent or carer. If you still feel your work does not impact children/young people, please move to section E.

UNCRC Right	How might your work further this right?	How might your work restrict this right?	Are there any particular groups impacted? i.e. children with disabilities
Best interests of the child	By addressing racialised inequalities within healthcare services and promoting equitable access, the Plan supports decision-making that prioritises children's wellbeing.	None Identified	Minority ethnic children.
Making rights real	Ensuring that minority ethnic children and young people know their rights in terms of accessing services and providing feedback.	None identified	New Scots, Asylum Seekers and Refugees

UNCRC Right	How might your work further this right?	How might your work restrict this right?	Are there any particular groups impacted? i.e. children with disabilities
Family guidance as children develop	Improving experiences for parents and carers from minority ethnic backgrounds supports families to guide and nurture children effectively.	None Identified	Families from minority ethnic backgrounds.
Life, survival and development	Actions promoting culturally competent maternity and neonatal care may improve health outcomes for children from minority ethnic backgrounds.	None Identified	Children from minority ethnic families.
Name and nationality	n/a	n/a	n/a
Identity	n/a	n/a	n/a
Keeping families together	By reducing racialised barriers to accessing healthcare and support services, the Plan helps families maintain stability and	None identified	Minority ethnic families, refugees, and asylum seekers.

UNCRC Right	How might your work further this right?	How might your work restrict this right?	Are there any particular groups impacted? i.e. children with disabilities
	wellbeing, which supports family unity.		
Contact with parents across countries	n/a	n/a	n/a
Protection from kidnapping	n/a	n/a	n/a
Respect for children's views	By promoting inclusive engagement and culturally sensitive communication with families, the Plan supports environments where children's voices are heard in care decisions.	None identified	Minority ethnic children, especially where language or cultural barriers exist.
Sharing thoughts freely	Creating psychologically safe spaces for families and communities to share feedback on services indirectly supports children's ability to express their views in	None identified	Children from minority ethnic backgrounds who may otherwise feel excluded.

UNCRC Right	How might your work further this right?	How might your work restrict this right?	Are there any particular groups impacted? i.e. children with disabilities
	healthcare settings.		
Freedom of thought and religion	Anti-racism actions include cultural competence training and respect for religious practices, ensuring children's beliefs are acknowledged in care (e.g., dietary needs, prayer spaces).	None identified	Children from minority ethnic and faith communities.
Freedom of association and peaceful assembly			
Protection of privacy	Ensuring that children and young people whose first language is not English are equipped with the knowledge that they have a right to access interpreters, minimising inappropriate use of family to undertake this role, therefore		

UNCRC Right	How might your work further this right?	How might your work restrict this right?	Are there any particular groups impacted? i.e. children with disabilities
	protecting privacy.		
Access to information	Culturally appropriate communication and interpretation services will help families access health information, supporting children's wellbeing.	None identified	Families with language barriers.
Responsibility of parents	n/a	n/a	n/a
Protection from violence	Trauma-informed approaches and culturally competent safeguarding practices help protect children from harm and ensure equitable access to support.	None identified	Minority ethnic children, refugee children.
Children without families	n/a	n/a	n/a
Children who are adopted	n/a	n/a	n/a

UNCRC Right	How might your work further this right?	How might your work restrict this right?	Are there any particular groups impacted? i.e. children with disabilities
Refugee children	Inclusive and trauma-informed approaches will improve access and experience for refugee and asylum-seeking children and families.	None identified	Refugee and asylum-seeking children.
Disabled children	Intersectionality recognised: actions promoting equity and culturally competent care may improve access and experience for disabled children from minority ethnic backgrounds.	None identified	Disabled children from minority ethnic families.
Enjoyment of the highest attainable standard of health	The Plan supports work to reduce racialised health inequalities and improve access to services, benefiting children and young people.	None identified	Minority ethnic children and families.
Review of a child's placement	n/a	n/a	n/a

UNCRC Right	How might your work further this right?	How might your work restrict this right?	Are there any particular groups impacted? i.e. children with disabilities
Social and economic help	By addressing racialised barriers to employment and healthcare, the Plan indirectly supports families' economic stability, which benefits children.	None identified	Minority ethnic families experiencing poverty.
Food, clothing and safe home	Partnership with community organisations and culturally competent care can help signpost families to support services, reducing inequalities that affect basic needs.	None identified	Refugee and asylum-seeking families, minority ethnic families in poverty.
Access to education	Health equity improvements (e.g., better maternity and early years care) contribute to children's readiness for learning and	None identified	Children from minority ethnic backgrounds and those in poverty.

UNCRC Right	How might your work further this right?	How might your work restrict this right?	Are there any particular groups impacted? i.e. children with disabilities
	reduce health-related barriers to education.		
Aims of education	n/a	n/a	n/a
Minority culture, language and religion	Respecting cultural identity through interpretation services and inclusive care pathways promotes children's sense of belonging and identity.	None identified	Minority ethnic and faith communities.
Rest, play, culture, arts	By promoting cultural inclusion and reducing discrimination, the Plan helps create environments where children feel safe to participate in cultural and recreational activities.	None identified	Minority ethnic children.
Protection from harmful work	n/a	n/a	n/a
Protection from harmful drugs	n/a	n/a	n/a

UNCRC Right	How might your work further this right?	How might your work restrict this right?	Are there any particular groups impacted? i.e. children with disabilities
Protection from sexual abuse	n/a	n/a	n/a
Prevention of sale and trafficking	n/a	n/a	n/a
Protection from exploitation	Inclusive engagement and awareness training for staff help identify and respond to risks of exploitation among vulnerable minority ethnic children.	None identified	Refugee and asylum-seeking children, children in poverty.
Children in detention	n/a	n/a	n/a
Protection in war	n/a	n/a	n/a
Recovery and reintegration	n/a	n/a	n/a

Section E – anything else?

Is there anything else you want to share with us?

This can be any further details about your work you think will be helpful, or can be any questions or queries you have in relation to Equality and Inclusion? Is there specific support you need from us?
The NHS Forth Valley Anti-Racism Plan is intended to be a living document, shaped by ongoing learning, feedback and evidence. While the Plan is not solely focused on children or other protected groups beyond race, it is expected to have indirect positive impacts across multiple characteristics through its influence on organisational culture, service design and workforce behaviour. Key points to highlight: Continuous Improvement: Implementation will be supported through existing governance and accountability arrangements, with progress monitored and reviewed regularly. Monitoring and Reporting: We will use a combination of quantitative data (e.g., workforce metrics, service access data) and qualitative insight (e.g., staff networks, lived experience feedback) to measure impact. Transparency: Progress will be published through equality reporting routes and shared with staff, patients and communities to build trust and accountability. Engagement: Ongoing engagement with minority ethnic colleagues, community partners and equality networks will ensure actions remain relevant and responsive to lived experience. Support Available: Advice and guidance will continue to be available from the Equality, Inclusion and Wellbeing Team to ensure equality considerations remain embedded throughout delivery of the Plan. Next Steps: As aforementioned, this EQIA will be reviewed regularly as part of the working group and updated to reflect any significant changes that are made to the scope or actions of the Plan.

Please complete the following details:

Name:	
Role:	
Department:	
Telephone:	
Email:	
Signature:	
Date:	

Please now save this form and send a copy to FV.EQIA@nhs.scot Someone will then be in touch to provide further guidance and support.

Useful Resources:

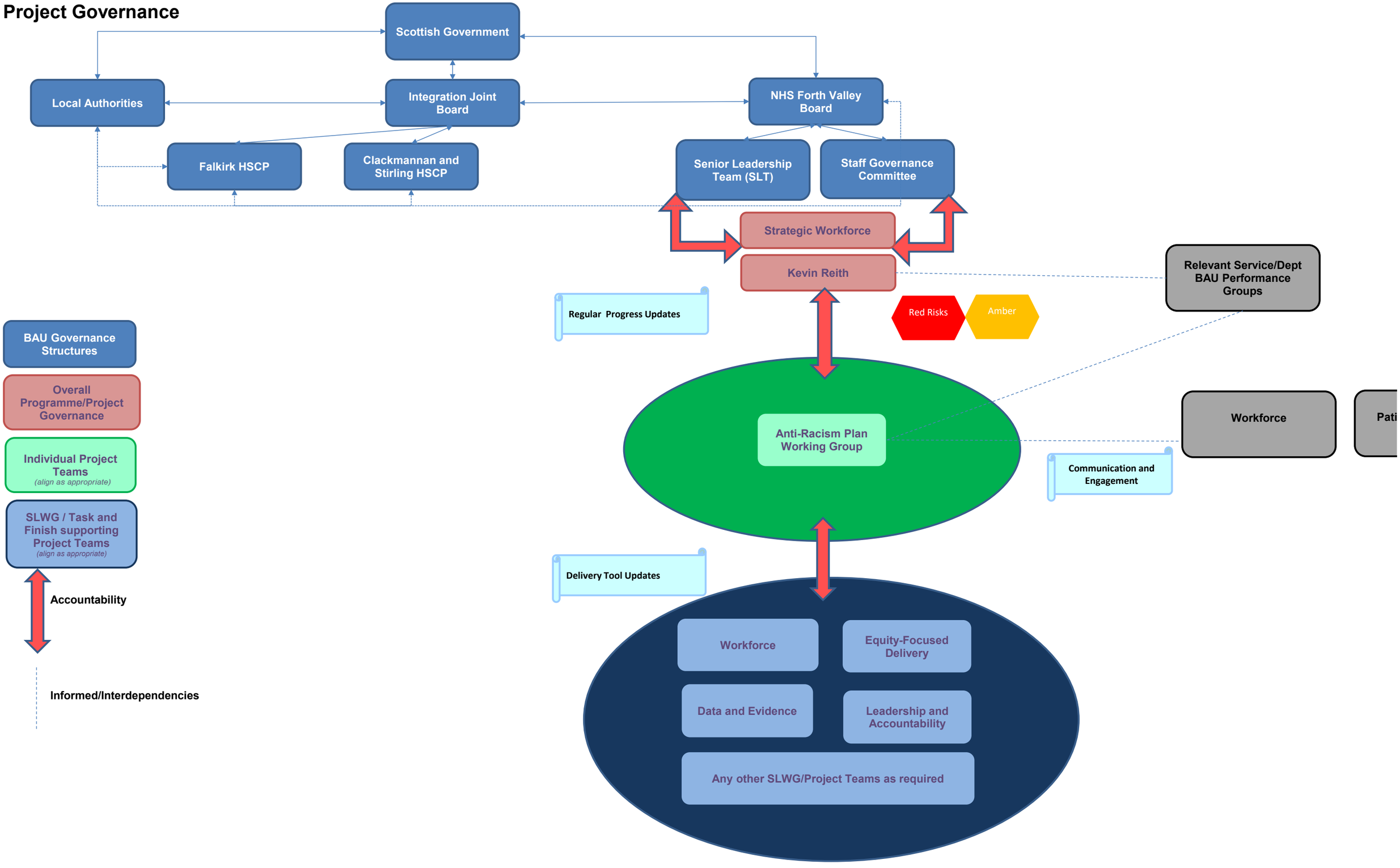
- Have you checked your document meets current accessibility requirements? Check the Guide for more information. If still unsure, email FV.equality@nhs.scot and we can support.
- You may find this video helpful: Scottish Government: EQIA - 'IT'S ALL ABOUT PEOPLE' (youtube.com)
- Or this guide: Fairer Scotland and equality impact assessments | NHS Education

Equality, Inclusion and Wellbeing Service Response and Next Steps:

Project Name: **NHS FV Anti-Racism Plan (2026 to 2029)**

Senior Responsible Owner (SRO):	Ross McGuffie
Project Leads:	Kevin Reith and Linda McGovern
Project Definition/Scope :	As an organisation, we are clear: racism has no place in NHS Forth Valley. Yet we acknowledge that racial inequality continues to affect our services, our workforce, and the experiences of the communities we serve. Scotland's demographic profile is changing and as an organisation we need to be agile, responsive and ready to adapt so that the care we deliver meets the demands of our increasingly diverse population. To achieve real and meaningful change, we must do more than acknowledge these inequalities- we must actively address them. Developing an Anti-Racism Plan allows us to set out a clear and purposeful approach, outlining our ambitions and the actions we will take. This plan represents our commitment to move beyond words and towards deliberate, sustained action to challenge and dismantle racism wherever it occurs across our systems. To achieve real, meaningful change to tackle racial inequalities, we recognise the need to create an impactful plan that details our approach and outlines our ambitions to drive meaningful change. Our Plan is our commitment to move beyond words and take deliberate, sustained action to challenge and dismantle racism wherever it occurs across our systems and our culture.
Start Date :	01/02/2026
End Date :	30/04/2029

Project Governance



Project Stakeholders

Project Name	NHS FV Anti-Racism Plan (2026 to 2029)
SRO	Ross McGuffie
Last updated by	
Last review date	

Key Stakeholders -

Project Role	Name	Job Title	Email

Implementation Group Membership

Project Role	Name	Job Title	Email

Project Plan / Gantt Chart

A project plan defines project goals and objectives, **specifies tasks and how goals will be achieved**, identifies what resources will be needed and associated budgets and timelines for completion and **defines all work** in a project and clearly **identifies who will do it**.

The project plan therefore provides a focused roadmap for exactly how to implement and complete a programme/project. It includes all the necessary information with sufficient detail clearly stating how the organisation will handle the project, including staffing, budgets, timelines, deadlines, the goals that need to be reached, and any metrics used to judge those goals. Time is often one of the more complicated resources to allocate during a project plan. Project steps are either interrelated (co-dependencies) or independent. Some tasks need to be done before others can be completed, while other tasks can be done at any time as long as they are finished before the project is complete; each task may also take a different amount of time to complete.

Plans must also factor in which specialists need to be working on which tasks to avoid having to reshuffle or assign to them different times. All this is done with the intent of meeting the project deadline, which typically occurs at project initiation (or a similar stage), with some time afterward allocated for maintenance or reviews

Number	Milestones:	Accountable for Milestone (Lead):	RAG status	Date from:	Date to:	Status:	% Complete	
NHS FV Anti-Racism Plan (2026 to 2029)				01/02/2026	30/04/2029			
1	**Project Start Up**							0.0
1.1	Undertake Review and Learnine from Previous Strataev and Outcomes	Rachel Tardito	Complete	01/02/2026	30/04/2026	IN DATE	0.0	
1.2	Complete Engagement Period - both staff and community	Rachel Tardito	Complete	01/02/2026	30/04/2026	IN DATE	0.0	
1.3	Collate feedback and data to inform 2025 Strategy	Rachel Tardito	Complete	01/02/2026	30/04/2026	IN DATE	0.0	
1.4	Develop Strategy	Rachel Tardito	Complete	01/02/2026	30/04/2026	IN DATE	0.0	
1.5	Complete final sense-check with key stakeholders	Rachel Tardito	On Plan	01/02/2026	30/04/2026	IN DATE	0.0	
1.6	Finalise Governance Arrangements for Strategy Approval	Kevin Reith	Complete	01/02/2026	30/04/2026	IN DATE	0.0	
1.7	Agree Reporting Process - Frequency / Templates /Governance Route	Kevin Reith	On Plan	01/02/2026	30/04/2026	IN DATE	0.0	
1.8	Create Communication Plan	Rachel Tardito	On Plan	01/02/2026	30/04/2026	IN DATE	0.0	
2	**Project Execution (Milestones)**							0.0
2.1	**Strateav Launch**							
	Finalise InTarcsatic Version	Rachel Tardito	On Plan	01/05/2025	30/04/2029	IN DATE	0.0	
	Finalise Easy-Read Version	Rachel Tardito	On Plan	01/05/2025	30/04/2029	IN DATE	0.0	
	Publish on 30th April 2025	Rachel Tardito	On Plan	01/05/2025	30/04/2029	IN DATE	0.0	
2.2	**Communication and Engagement for Launch**							
	Liaise with Comms colleakeues around promotion of launch	Rachel Tardito	On Plan	01/05/2025	30/04/2029	IN DATE	0.0	
	Promote and share launch to kev stakeholders	Rachel Tardito	On Plan	01/05/2025	30/04/2029	IN DATE	0.0	
	Link to wider communication plan	Rachel Tardito	On Plan	01/05/2025	30/04/2025	OVERDUE	0.0	
2.3	**Measurement and Evaluation**							
	Agree upon measurement indicators to be reported alongside progress updates	Kevin Reith	On Plan	01/05/2025	30/04/2025	OVERDUE	0.0	
	Liaise with Pentana colleaques to suoport develoament of dashboard	Rachel Tardito	On Plan	01/05/2025	30/04/2025	OVERDUE	0.0	
	Liaise with Risk colleaques to support development of risk register	Rachel Tardito	On Plan	01/05/2025	30/04/2029	IN DATE	0.0	
2.4						OVERDUE	0.0	
						OVERDUE	0.0	
						OVERDUE	0.0	
2.5						OVERDUE	0.0	
						OVERDUE	0.0	
						OVERDUE	0.0	
2.6						OVERDUE	0.0	
						OVERDUE	0.0	
						OVERDUE	0.0	
						OVERDUE	0.0	
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						OVERDUE	0.0	
						OVERDUE	0.0	
3	**Project Handover and Closure**							0.0
3.1	Handover and prepare for BAU					OVERDUE	0.0	
3.2	Assess & Complete Project Risks & Issue Registers					OVERDUE	0.0	
3.3	Complete Project Closure Report. including Lessons Lea					OVERDUE	0.0	
3.4	Seek Authority to Close Project					OVERDUE	0.0	

Project Plan Key
Complete
Started
Planned/Not started

Scottish Government Focus Area	Action title	Action detail	Owners	Year one	Year two	Year three	Measurement of success	Evidence sources	Start date	End date	RAG status	Progress Updates
National Alignment Learning and Improvement	Reviewing Initial Request	Review of Scottish Government DL23 (2024) to better understand the ask and agree next steps.	Linda McGovern and Rachel Tardito	Annual review against checklists and feedback from SG	Annual review against checklists and feedback from SG	Annual review against checklists and feedback from SG	Positive feedback from SG	Progress against checklists	Dec-24	Apr-29	In Progress	February and July SG returns submitted with positive feedback received. Suggested builds and improvements actioned within draft plan and approach.
National Alignment Learning and Improvement	Connecting with Scottish Government	Connecting with key stakeholders and leads from Scottish Government to have initial planning meetings and discuss proposed approach.	Linda McGovern and Rachel Tardito	Ongoing Participation and Learning	Ongoing Participation and Sharing Progress and Learning	Ongoing Participation and sharing evidence of good practice and success within own Plan	Growing body of evidence available to illustrate progress and share at a national level	All Plan data	Jan-26	Apr-29	In Progress	First SG national meeting took place 15.01.2026
National Alignment Learning and Improvement	National Benchmarking	Undertake national benchmarking, learning from areas who have already established successful Anti-Racism Plans and arrange opportunities to connect.	Rachel Tardito	Reviewing, learning and connecting	Collaboration and partnership working with other Boards	Alignment to a Once for Scotland approach and aim to present nationally	Co-production of resources and events and opportunity to deliver success story at a national level i.e. NHS Scotland Event	Positive feedback from national colleagues and increase in requests for collaboration	Jan-25	Apr-29	In Progress	
Workforce	Strengthen Staff Ethnic Diversity Network	Strengthen our Ethnic Diversity Staff Network ensuring effective executive sponsorship, protected time, diverse executive committee and increased awareness and membership.	Kevin Reith	Increase awareness and membership	Embed network into governance and regular reporting	Network demonstrably influences policy and workforce decisions	Active network with evidence of issues raised leading to organisational change	Staff network terms of reference; meeting minutes; Board papers	Jan-25	Apr-29	In Progress	
Workforce	Formalise staff network escalation routes	Create a clear process for issues raised by staff networks to be logged, escalated and responded to.	Kevin Reith and Rachel Tardito	Design and agree escalation process	Apply process consistently and monitor responses	Review effectiveness and refine based on feedback	Timely senior responses and staff confidence in escalation routes	Escalation logs and IR1s; senior leadership responses; staff feedback			Not Started	
Workforce	Review racism and discrimination incident reporting routes	Evaluate and improve accessibility, safety and effectiveness of racism reporting mechanisms.	Kevin Reith, Linda McGovern, Cameron Raeburn and Rachel Tardito	Baseline review and staff consultation.	Implement redesigned routes and guidance	Evaluate outcomes and staff confidence	Increased reporting confidence and improved experience of handling cases	Incident reporting review report; staff survey results	Jan-26	Apr-29	In Progress	Working with Health and Safety colleagues to expand upon current IR1 reporting template for incidents of discrimination to allow for protected characteristics questionnaire that will aid data collection and targetted response and learning.
Workforce	Provide specialist investigation training	Train investigators in racism, racial trauma and culturally competent investigation practice.	Linda McGovern	Identify investigators and deliver training	Refresh training and undertaken learning audit and review	Continuous cycle of improvement, benchmarking against Once for Scotland data and feedback	Improved quality, fairness and consistency of investigations	Training records; investigation quality audits	Jan-26	Apr-29	In Progress	Operational HR colleagues have created a Mock Investigation Report - Guidance and FAQ's tool
Workforce	Enhance support for staff experiencing racism	Strengthen and signpost wellbeing and aftercare support for affected staff.	Working Group	Map and promote available support	Monitor uptake and staff experience	Refine support offer based on feedback	Staff report feeling supported following racist incidents	Wellbeing service usage data; staff experience surveys including iMatter			Not Started	
Workforce	Conduct talent pipeline diagnostic	Analyse recruitment, retention and progression barriers for minority ethnic staff.	Linda McGovern	Complete diagnostic and agree actions	Implement targeted interventions	Evaluate impact on workforce outcomes	Clear understanding of barriers and targeted action taken	Workforce data analysis; recruitment and progression reports including ethnicity pay gap report			Not Started	
Workforce	Targeted leadership development	Introduce mentoring and sponsorship schemes that support minority ethnic staff.	Jenny McCusker and Rachel Tardito	Design programme and recruit first cohort	Deliver and evaluate programme	Scale programme where impact evidenced	Improved progression rates into senior roles	Programme participation data; promotion statistics	Oct-25	Apr-29	In Progress	Wider links to new Leadership and Management Framework and Leadership for All event led by OD. Working closely to ensure alignment to Plan.
Workforce	Strengthen senior allyship	Define expectations and support senior leaders as anti-racism allies.		Agree allyship expectations and development	Monitor participation and behaviours	Embed allyship into leadership culture	Visible senior allyship influencing culture and decisions	Leadership development records; 360 feedback			Not Started	
Data and evidence	Annual Board review of ethnicity data	Board-level review of race and ethnicity data quality and use.		Baseline data quality assessment	Implement improvement actions	Routine Board oversight with improved data quality	Improved completeness and accuracy across datasets	Board data quality papers; ethnicity data dashboards			Not Started	
Data and evidence	Ethnicity data improvement plan	Develop and resource a time-bound plan to address data gaps.		Agree improvement plan and priorities	Deliver improvement actions	Sustain improvements as business as usual/mainstreaming	Demonstrable reduction in unknown/refused ethnicity data	Data quality improvement plan; dataset completeness reports			Not Started	
Data and evidence	Improve staff and patient data confidence	Explain why ethnicity data is collected and how it is used.		Develop communications and training materials	Roll out training and communications	Evaluate confidence and refine approach	Increased willingness to share ethnicity data	Training attendance logs; confidence surveys			Not Started	
Data and evidence	Cross-functional evaluation group	Create group overseeing monitoring and evaluation of the plan.		Establish group and framework	Use framework to monitor progress	Refine framework based on learning	Clear evidence of impact monitoring and learning	Evaluation framework; progress reports			Not Started	
Data and evidence	Share equality data insights with staff	Publish and communicate findings from equality data analysis.		Agree reporting approach and develop Pentana dashboard	Regularly share insights	Demonstrate use of insights in decision-making	Staff awareness of inequalities and action taken	Equality dashboards; internal communications			Not Started	
Leadership and accountability	Publish Board anti-racism commitment	Agree and publish a visible Board-level anti-racism commitment.		Draft and approve commitment (part of launch)	Communicate and reinforce commitment	Review and refresh commitment	Clear organisational understanding of commitment	Published commitment; Board minutes; staff communications			Not Started	
Leadership and accountability	Embed oversight within governance structures	Incorporate measurable anti-racism objectives into the new Equality, Inclusion and Wellbeing Service Pentana dashboard and utilise this to help inform governance and progress reports		Agree objectives and metrics and create dashboard	Monitor progress and review year one evidence and reports to build upon any metric gaps or additional data needed	Strengthen accountability where needed and utilise dashboard data to report on Equality Outcome progress as part of PSED reporting cycle.	Clear ownership and delivery against objectives and evidence of improvement via key metrics	Governance feedback and Pentana data analytics			Not Started	
Leadership and accountability	Review policies through anti-racism lens	Review key policies to identify structural racism.		Identify priority policies	Revise policies based on findings	Evaluate impact of changes	Policies demonstrably reduce racialised barriers	Policy review logs; revised policy documents			Not Started	

Leadership and accountability	Diversify decision-making spaces	Improve diversity across Boards and senior groups.		Set baselines and targets, agreed by Board and aligned with national approach	Implement recruitment and development actions	Demonstrate sustained improvement	Increased diversity in leadership and governance	Board composition data; appointments reports			Not Started	
Leadership and accountability	Clarify Board-level anti-racism roles and responsibilities	Clarify and formalise Board-level roles and responsibilities, including Anti-Racism Senior Ally remit and governance routes.		Agree roles and governance routes and confirm Senior Ally	Embed roles and repsonsibilities into Board objectives	Roles sustained and refreshed, building upon success	Roles visible and leadership engagement evidenced through attendance at Ethnic Diversity Network and community events/opportunities for hearing lived experience input and feedback	Board and Senior Leader PDPs and Objectives, Feedback from engagement events, comms pieces			Not Started	
Leadership and accountability	Strengthen governance and scrutiny	Introduce routine Board scrutiny of anti-racism progress.		Agree reporting and governance cycle	Use data to challenge and improve	Embed scrutiny as standard practice	Robust challenge and accountability evident	Board and committee paper			Not Started	
Equity-focused service delivery	Strengthen equality impact assessments	Ensure EQIAs are completed early and inform decisions.		Review and improve EQIA process	Embed EQIAs into service decisions	Evaluate quality and impact	Service changes clearly informed by EQIAs	EQIA documents; decision papers, feedback			Not Started	
Equity-focused service delivery	Improve use of PHS/HIS equalities data	Embed use of PHS/HIS equalities data across services.		Promote tools and training	Use data to identify inequities	Demonstrate service improvement	Data routinely informs service redesign	PHS datasets; service performance reports			Not Started	
Equity-focused service delivery	Use patient feedback through an equity lens	Analyse complaints and feedback by ethnicity.		Establish analysis approach	Use findings to inform improvements	Evaluate impact on experience	Reduced inequities in patient experience	Complaints analysis; patient experience surveys			Not Started	
Equity-focused service delivery	Formalise community collaboration	Establish ongoing collaboration with community and faith groups.		Map partners and agree engagement model	Co-design improvements	Sustain partnerships	Evidence of co-produced service changes	Community engagement records; co-production outputs			Not Started	
Equity-focused service delivery	Address inequalities in T2D and CVD care	Reduce inequalities in prevention, monitoring and treatment.	Jenny Hynes and Working Group	Baseline analysis of inequalities	Implement targeted interventions	Demonstrate reduced variation	Reduced gaps in access and outcomes	Clinical audit data; outcome dashboards			In Progress	Targtted outreach and bespoke resources for minority ethnic patients in response to evidence
Equity-focused service delivery	Strengthen perinatal equity actions	Improve outcomes and experiences for minority ethnic parents.	Donna Brough and Working Group	Analyse data and feedback	Implement quality improvement actions	Demonstrate improved equity	Improved experiences and outcomes for minority ethnic parents	Perinatal audits; PMRT/SAER reviews			In Progress	Experience surveys for minority ethnic women already underway and improvement actions being taken
Equity-focused service delivery	Improve equity in mental health services	Identify and address barriers to access and quality.	Richard Payne and Working Group	Assess barriers and experiences	Implement targeted improvements	Evaluate outcomes	Improved access, experience and outcomes	Mental health access and outcomes data; service user feedback			In Progress	Improvement work ongoing at service-level and as part of Population Mental Health Stategy

Phase	Action	Description/Detail	Target Audience	Channel / Format	Key Message / Purpose	Lead(s)	Timing	Notes / Considerations	RAG Status	Evidence/Link
Development	Initial Joint Statement	Joint statement from Chief Executive and Ethnic Diversity Network Chair following Scottish Government ask for all boards to develop an Anti-Racism Plan	Workforce	Staffnet, Network mailing list and MS Teams channel, Manager cascade	To inform staff of Anti-Racism Plan development, encourage involvement and promote Ethnic Diversity Network	Elsbeth Campbell and Rachel Tardito	Jan-25	Ensure link to full Scottish Government DL23 and signposting for support	Complete	https://scottish.sharepoint.com/:u:/r/sites/FV-HR-Connect/SitePages/NHS-Forth-Valley-Anti-Racism-Plan-%E2%80%93-Joint-Statement.aspx?csf=1&web=1&e=JnrWat
Development	Ethnic Diversity Network Promotion	Promotion of upcoming Ethnic Diversity Network Events to encourage attendance and engagement to help shape plan development via lived experience input	Workforce	Staffnet, Network mailing list and MS Teams channel, Manager cascade	Join us and help to shape the development of our Anti-Racism Plan	EDN Executive Committee	Feb 25 - Dec 25	Support from Staffside colleagues and Equality, Inclusion team to help promote easy-to-miss staff groups. Consider hybrid attendance or other ways to participate, i.e. MS Forms and via email.	Complete	MS Teams Channel for EDN
Development	Targetted Outreach	Emails and targetted messages/calls to support feedback from key stakeholders and local communities	Public	Email, telephone, face-to-face	Gain insight and feedback - we want to hear your thoughts and experiences	Equality, Inclusion and Wellbeing Service and Comms	Jan 25 to Dec 25	Consider digital exclusion and need for utilising trusted partners to support	Complete	Feedback incorporated into final draft of plan
Development	Governance Papers	Papers for governance meetings to support approval journey ahead of final sign-off at January 2026 Board meeting	Board and SLT	Governance Template	Please provide feedback on current draft of Plan and assurance of progress	Linda McGovern, Aileen Love, Stacey Gourlay and Rachel Tardito	October 25 to Jan 26	Ensure utilising new template	In Progress	Board meeting 27th January, final draft pending sign-off
Soft Launch	Internal announcement	Chief Executive and Board Chair message introducing our Anti-Racism Plan	Workforce	Staffnet, Staffbrief, Email, EDN cascade	Leadership commitment and purpose of the plan	Communications	Feb-26	Clear and inclusive language with a call to action	In Progress	
Soft Launch	Public announcement	Initial public message announcing forthcoming Anti-Racism Plan after Board approval	Public	Website, social media	Commitment to tackling racism	Communications	Feb-26	High-level only, more to follow	In Progress	
Soft Launch	Manager cascade	Manager briefing pack cascaded to teams	Managers	Email, team meetings	What the plan means locally and how to get involved	Working Group	Feb-26	Include FAQs	In Progress	
Soft Launch	Team discussion prompts	Structured prompts for team conversations	Workforce	Team meetings, huddles, face-to-face	Safe discussion and reflection	Working Group	Feb-26	Psychological safety will be a key theme and require support for teams to help them create the conditions	In Progress	
Soft Launch	Scottish Government Update	Prepare email update with copy of plan and relevant documents to share with Scottish Government colleagues	Scottish Government	Email	Provide update and assurance	Linda McGovern, Aileen Love, Stacey Gourlay and Rachel Tardito	Feb-26	Ensure links to focus areas and checklists (take from action log)	Not Started	
Official Launch	Launch event(s)	Formal launch aligned to Elimination of Racial Discrimination Day	Workforce	Event, video, Staffnet comms, posters	Commitments and involvement	Working Group	Mar 26 to April 2026	Be mindful of Eid and easy-to-miss staff groups	In Progress	
Official Launch	Publish plan with video	Publish full plan, summaries and video	Public	Website, social media, print	Transparency and accountability	Working Group	Mar 26 to April 2027	Accessible formats - support and guidance sought from comms colleagues	Not Started	
Implementation	Staff roadshow	Engagement sessions across sites and pop-ups/walk-rounds	Workforce	In-person	Listening and engagement	Working Group and Equality, Inclusion and Wellbeing Service	Mar to Jun 26	Account for various sites and shifts	Not Started	
Implementation	Community engagement	Engagement with patient groups and faith centres	Public	Community venues	What the plan means for patients and how best we can keep people involved and updated	Working Group and Equality, Inclusion and Wellbeing Service	Mar to Dec 26	Trusted intermediaries and third sector partners will be key. Building upon previous engagement and outreach work	Not Started	
Ongoing	Visual materials	Posters and displays explaining the plan and highlighting ways to get involved	All Audiences	Posters, displays	Visibility and reinforcement	Working Group and Equality, Inclusion and Wellbeing Service	Ongoing	Mitigate digital exclusion and increase promotion. Consider accessibility and alternative languages	Not Started	
Ongoing	Social media activity	Planned social content highlighting progress	All Audiences	Social media	Transparency and engagement	Communications	Ongoing	Moderation required and aligned to wider Engagement and Participation Framework approach	Not Started	
Ongoing	Diversity Calendar	Linking to diversity calendar events	Workforce	Staffnet, Staffbrief, Email, EDN cascade and pop-up sessions and events	Align to wider Equality and Inclusion Strategic Framework	Equality, Inclusion and Wellbeing Service	Ongoing	Close collaboration with EDN and Staffside	In Progress	
Ongoing	Campaigns	Linking to national health promotion campaigns	All Audiences	Multimedia	Align to national programmes and campaigns	Working Group	Ongoing	Additional targetted outreach actions and resulting comms will be considered for each event	In Progress	
Ongoing	Celebrating Success	Showcasing positive examples of work already underway and highlighting appreciation for our diverse workforce and communities	All Audiences	Comms Posts and Videos	Building upon success and appreciation	Working Group	Ongoing	Support and guidance from Comms colleagues	In Progress	
Ongoing	Storytelling	Harnessing the power of storytelling, from both staff and patients to highlight key themes	All Audiences	Comms Posts and Videos	Bringing the themes, actions and learning from our Anti-Racism Plan to life.	Working Group	Ongoing	Support and guidance from Comms colleagues	In Progress	
Implementation	Anti-racism training promotion	Promote mandatory and developmental anti-racism training opportunities	Workforce	Staffnet, Network mailing list and MS Teams channel, Manager cascade	Promoting awareness and encouraging engagement and uptake	Working Group	Ongoing	Continuous cycle of raising awareness, reviewing and improving within a learning system	Not Started	
Implementation	Feedback and reporting routes	Promote safe routes for raising concerns and sharing experiences of racism	Workforce	Staffnet, Network mailing list and MS Teams channel, Manager cascade	Raising awareness	Working Group	Ongoing	See it, Say it, Act on it - ongoing improvement and awareness cycle	Not Started	
Implementation	Feedback and reporting routes	Promote safe routes for raising concerns and sharing experiences of racism	Public	Multimedia	Raising awareness and educating around rights	Working Group	Ongoing	See it, Say it, Act on it - ongoing improvement and awareness cycle	Not Started	
Conclusion	Outcomes and impact report	Publish a clear summary of outcomes, metrics, and learning from the Anti-Racism Plan	All Audiences	TBC	Demonstrate progress and celebrate success whilst acknowledging improvements still to be made	Working Group	Mar-29	TBC	Not Started	
Conclusion	Thank you and recognition messaging	Acknowledge contributions of staff, patients, and communities involved	All Audiences	TBC	Celebration and appreciation	Board and Senior Leaders	Mar-29	TBC	Not Started	
Conclusion	Next phase communications	Set expectations for next steps, continuous improvement, and ongoing accountability	Board and SLT	TBC	Thinking ahead, keeping momentum	Board and Senior Leaders	Mar-29	TBC	Not Started	

Risk Register

The purpose of the Risk Register is to provide a record of identified risks relating to the project, including their status and history.
It is used to capture and maintain information on the identified threats and opportunities relating to the programme/project.
The risk register should be monitored by the Programme/Project Managers on a regular basis.
Entries should be made as soon as it is the risk is identified and updated as the risk is mitigated, once the risk is resolved the entry should be closed.

Programme Name	**NHS FV Anti-Racism Plan (2026 to 2029)**
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					Baseline				Post mitigation									
Number:	**Who Identified Risk?**	**Date Raised:**	**Risk Category:** *(See Risk Scoring - Decision' tab to help decide the most appropriate category using the 'Impact' section*	**Risk Description:** *(Include 3 essential components in this narrative; Cause, Risk Event and Impact for example, if ……..(cause), there is a risk that …… (what event will happen), resulting in…….. (impact on project))*	**Likelihood (baseline)**	**Impact (baseline)**	**Risk Score (baseline)**	**Mitigation:** *(Measures to be put in place to effectively manage the risk to an acceptable level)*	**Mitigation Owner:** *(Who is responsible for implementing the mitigation)*	**Likelihood**	**Impact**	**Risk Score (Mitigated)**	**Additional Mitigation:** *What further actions need to be taken to reduce the risk to within a tolerable level)*	**Additional Mitigation Owner:**	**Additional Mitigation Date Identified:**	**Review Notes:** (Note the outcome of the review and next steps to respond to the risk and using this information identify 'Review Decision')	**Review Decision:** *(refer to Risk Scoring-Matrix tab to support decision)*	**Last Review Date:** *(Last date risk was reviewed and post mitigation re-assessed)*	**Next Review Date:** *(Date risk is scheduled for a review)*	**Status:** *(Open/Closed)*
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LIKELIHOOD

Likelihood - What is the likelihood of the risk occurring? (assess using the criteria below)

Category	1 = Rare	2=Unlikely	3=Possible	4=Likely	5=Almost Certain
Applies to all	It is assessed that the risk is very unlikely to ever happen.	It is assessed that the risk is not likely to happen.	It is assessed that the risk may happen.	It is assessed that the risk is likely to happen.	It is assessed that the risk is very likely to happen.
	Will only occur in exceptional circumstances.	Unlikely to occur but potential exists.	Reasonable chance of occurring - has happened before on occasions.	Likely to occur - strong possibility.	The event will occur in most circumstances.

IMPACT

Impact – What could happen if the risk occurred?
Assess for the most appropriate category and use the highest score identified.
The impact scale is from a project level perspective.
It reflects the key areas that if impacted could prevent the project achieving its priorities and objectives.
The scale is a guide and cannot cover every type of impact therefore judgement is required.

Category	1=Negligible	2=Minor	3=Moderate	4 =Major	5 =Extreme
Patient / Staff Experience	Project progress resulting in reduced quality patient experience and/or clinical outcome; not directly related to delivery of clinical care.	Project progress resulting in unsatisfactory patient experience and/or clinical outcome; directly related to care provision – readily resolvable.	Project progress resulting in unsatisfactory patient experience and/or clinical outcome; short term effects – expect recovery less than 1 week	Project progress resulting in unsatisfactory patient experience and/or clinical outcome; long term effects - expect recovery over more than 1 week.	Project progress resulting in unsatisfactory patient experience and/or clinical outcome; continued ongoing long-term effects.
Clarity of understanding of Brief / Objectives / Scope Creep	Barely noticeable increase or reduction in Scope, Brief, Objectives or Plan.	Controlled minor increase or reduction in Scope, Brief, Objectives or Plan.	Uncontrolled increase or reduction in Project Scope, Brief, Objectives or Plan. A reduction in Quality. A misunderstanding affecting Project delivery.	Significant Project over-run. Significant effect on Quality. Failure to deliver key Objectives.	Inability to meet project Objectives. Reputation of the organisation seriously damaged.
Governance / Communication / Project Plan	Short term project progress issue due to communication and/or governance issues.	Reduced project progress due to communication and/or governance issues.	Late delivery of key project objectives due to lack of decision making and/or communication.	Uncertain delivery of key project objectives due to lack of decisions and/or communication.	Inability to progress project and/or deliver key objectives due to lack of decisions and/or communication.
Injury / Illness (physical & psychological) to Patient, Visitor or Staff	Adverse event leading to minor injury, not requiring first aid. No staff absence.	Minor injury or illness, first aid treatment required. Up to 3 days staff absence	Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling. RIDDOR over 7- day absence due to injury and/or dangerous occurrences.	Major injuries, long term incapacity, disability (e.g. loss of limb) requiring medical treatment and/or counselling. RIDDOR over 7- day absence due to major injury and/or dangerous occurrences.	Incident leading to death(s) or major permanent incapacity.
Complaints / Claims	Project related verbal complaint – resolved at project level.	Justified written complaint peripheral to clinical care caused by project.	Justified complaint caused by project; below excess claim.	Multiple justified complaints caused by project; claim above excess level.	Multiple claims or single major claim caused by project. Complex justified complaint caused by project.
Stakeholder Engagement / Adverse Impact on Project Delivery (Internal / External)	Interruption to project plan which does not impact on the delivery of key actions or the ability to continue to progress the project.	Short term disruption to project delivery with minor impact on delivery of key actions.	Some disruption in project progress with unacceptable impact on project delivery. Temporary loss of ability to continue project delivery. Resources stretched. Pressure on other project resources.	Sustained loss of project progress which has serious impact on project delivery resulting in major contingency plans being invoked. Temporary project suspension.	Affecting critical path action on project plan. Disruption to project plan leading to significant “knock on” effect. Inability to progress project.
Staffing Competence	Short term, low project resource level, temporarily reducing project progress (less than 1 day).	Ongoing low project resource level reducing project progress and/or quality. Minor error due to lack of or ineffective training or implementation of training.	Late delivery of key project objectives due to lack of resource. Moderate error due to lack of or ineffective training or implementation of training. Ongoing problems with project resource levels.	Uncertain delivery of key project objectives due to lack of resources. Major error due to lack of or ineffective training or implementation of training.	Non-delivery of key project objectives due to lack of resources. Loss of key project staff. Critical error due to lack of or ineffective training or implementation of training.
Financial (breaching tolerances defined within the PID)	Negligible project financial impact, breach exceeding tolerance by less than £5k.	Minor project financial impact, breach exceeding tolerance by £5k - £25k.	Significant project financial impact, breach exceeding tolerance by £25k - £50k.	Major project financial impact, breach exceeding tolerance by £50k - £100k.	Severe project financial impact, breach exceeding tolerance by more than £100k.
Inspection / Audit /Compliance / Health and Safety / Infection Control	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by project action.	Challenging recommendations that can be addressed with appropriate action plan. Improvement Notice.	Enforcement/prohibition action. Low Rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale or public attitudes.	Local media - long-term adverse publicity. Significant effect on staff morale/public perception of the organisation. Local MSP/SEHD interest.	National media adverse publicity less than 3 days. Public confidence in the organisation undermined.	National/International media adverse publicity, more than 3 days. MSP/MP/SEHD concern (Questions in Parliament). Court Enforcement or Public Enquiry or FAI.

Likelihood Score	Impact Score				
	1	2	3	4	5
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5
			Green	1-3	Low
			Yellow	4-6	Moderate
			Amber	8-16	High
			Red	20-25	Extreme

Review Decision	
Tolerate	This is the decision to accept the risk at its current level. The ability to do anything may be limited, or the cost of taking action may be disproportionate to the benefit gained. This response must be viewed in the context of the organisation's risk appetite. It is not acceptable to tolerate a risk above our stated appetite.
Treat	This is the decision to retain the activity or process creating the risk and to take action to implement risk controls that reduce either the likelihood of the risk occurring or minimising the impact.
Transfer	This is the decision to transfer the impact of the risk either in full, or in part, to a third party. The most common form of risk transfer is insurance.
Terminate	This is the decision to stop doing the activity associated with the risk. This may not always be possible and may create risks elsewhere as a result.

Issue Log

The purpose of the Issue Log is to capture and maintain information an **all** the issues that are being formally managed.
The issue log should be monitored by the Programme/Project Managers on a regular basis.
Entries should be made as soon as the issue is identified and updated as the issue is progressed, when the issue is resolved the entry should be closed.

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Score	Description	Issue Rating
5	Cannot go live without resolving this issue	SHOWSTOPPER
4	Can continue but with serious impact on the continued effectiveness of the project	SIGNIFICANT
3	Can continue, ongoing impact on the delivery of the project	NORMAL
2	Can continue, occasional/low impact on the project	MINOR
1	Can continue, no significant impact on the project	LOWEST

Number:	**Date Raised:**	**Raised By:**	**Issue Description:** *(What has actually happened in the project you hadn't expected/planned)*	**Issue Type:** *(Request for Change, Off Specification, Problem/Concern)*	**Issue Score:** *(Refer to matrix above)*	**Mitigating Action:** *(what needs to be done; ensure actions are carried over to the action log with owner and timelines and/or recorded on the decision log if within tolerances or change control followed for a change to approved plans)*	**Action Agreed by:** *(Who approved the mitigation)*	**Action Due Date:** *(date mitigation should be completed)*	**Issue Owner:** *(Responsible for delivering the mitigation)*	**Issue Priority:** *(Helps 'Issue owner' prioritise when there are a number of open issues)*	**Latest Review Date:**	**Review Notes:** *(refer to action log for the most recent position and record overview of discussions in respect of progress / next steps here ensuring additional actions are carried back over to the action log)*	**Escalate? Y/N**	**Date Resolved:**	**Status:** *(Open / Closed)*
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Decision Log

The decision log is used as a communication tool to appraise stakeholders on how a decision was reached, the options considered and who approved the decision.
It should capture all the decisions taken throughout the life of the programme/project to avoid the rehashing of options by maintaining a clear record and thereby reducing the likelihood of duplication and avoiding inefficiencies.
These must be reported as part of the highlight report or may require to be escalated out with the agreed reporting period by an exception report or where there is a change to the baseline/standards this will require to be added to the Change Control Log subject to the project tolerances delegated.
A clear audit trail of the decisions and a record of the evidence, noting the file path to easily locate information or by embedding a document, is essential.

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Number:	**Outline Decision Point:** *(Reason decision is required)*	**Outline Alternatives Solutions Considered:** *(Options Appraisal)*	**Decision Proposed:** *(Recommendation from options considered)*	**Impact of Decision:** *(If change to Project Plan/Timelines reported retain detail on this Log but please follow Change Control Process)*	**Proposed by:**	**Proposed Date:**	**Status:** *(Approved, Pending, Declined, Abandoned)*	**Approved by:** *(ensure Change Control Approval is already in place if required)*	**Decision Date:**	**Evidence:** *(document the type of evidence i.e. minutes, email etc and include the file path where information is saved or embed the document)*	**Comments / Resulting Actions:** *(ensure actions are carried over to the action log with owner and timelines)*
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Lessons Log

The lessons log is a programme/project repository for lessons that apply to this and future programmes/projects.
Some lessons may originate for other programmes/projects and these should be captured on this lessons log for input to this current programme/project approach and plans.
Some lessons may originate from within the programme/project itself, where new/experience (both good and bad) can be passed on to others to inform development of their programme/project plans supporting continued improvement and reducing duplication.
Information can be captured from a number of areas such as lessons logs from other projects, flash reports, highlight reports, observations and experiences of the programme/project as it progresses.

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Last updated by	
Last review date	

Lesson Type: *(select from list below)*	**Source of Learning:** *(is it from a previous project or this project? Select from list below)*	**What happened?** *(detail event - good or bad)*	**Why did it happen?** *(causes/trigger; was this a previously identified Threat/Opportunity, were there early warning indicators)*	**How did it affect the project?** *(describe how this positively or negatively impacted the project e.g. delay to timelines, financial impact, good team working, improvement to process)*	**What we did...** *(describe actions or steps taken)*	**What we learned…** *(what others should do or avoid doing in the future)*	**Date Logged:**	**Logged by:**	**Priority:** *(indicate priority level to help others undertake review and prioritise inclusion in future projects)*

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NHS FV Anti-Racism Plan: Communications and Engagement Approach

What is the purpose of this document?

This document provides working group members, SLT and Board members with a clear, high-level overview of the communications and engagement approach to support the launch and implementation of our new NHS Forth Valley Anti-Racism Plan. Our approach is designed to build awareness, understanding, and active participation amongst colleagues, patients and service users, and wider partners. It demonstrates a visible leadership commitment to the success of our Plan and identifies key touchpoints for engagement and collaboration.

What do we want to achieve via our communications and engagement?

- Clearly articulate why our Anti-Racism Plan matters and what it means in practice, encouraging ownership at every level – we all have our part to play.
- Build trust, credibility and buy-in through transparent, inclusive, and culturally sensitive communications and targeted outreach.
- Enable colleagues and patients to understand how they can contribute and the different ways they can get involved.
- Reach diverse audiences using a mix of digital and non-digital channels to mitigate against digital exclusion and reach easy-to-miss groups.

Who are our target audiences?

Internal	External
Entire Workforce - *including HSCPs, Serco, Students and a targeted focus on out-of-hours and community staff groups, who report often feeling excluded or easy-to-miss.*	**Patients and Service Users –** *ensuring we share information in an accessible way with our local population and those who access our services.*
Key Stakeholders – *including senior leaders, board members and those who's day-to-day role has a clear remit for direct involvement with progressing key actions associated with this work and encouraging buy-in and participation at all levels.*	**Friends, Relatives and Carers –** *ensuring we consider the wider reach for those supporting our patients and service users.*
Ethnic Diversity Network	**Community Representatives and Third Sector Organisations –**

	including Faith groups/leaders, advocates, and both local and national third sector groups.
Primary Care Colleagues – *often first point of contact for patients, including New Scots.*	**Partner Organisations –** HSCPs, IJBs and Local Authority colleagues, Police Scotland and local Colleges and Universities – link with Anchor approach.
Scottish Government – *liaising with Scottish Government as required to provide updates.*	

What is our Phased Approach?

1. Soft Launch – Late February /Early March (following Board approval end of February 2026)

The soft launch focuses on awareness-raising and preparing the organisation for meaningful engagement. Key activity includes:

- Initial internal joint message from the Board Chair and Chief Executive outlining commitment, intent, and next steps.
- External comms message to celebrate the launch of our new Anti-Racism Plan (Comms colleagues have already planned and prepared).
- Cascade of the Anti-Racism Plan and supporting materials to teams via managers and senior leaders with provision of discussion prompts and FAQs to support team-level conversations and engagement.
- Early engagement with both our Staff Ethnic Diversity Network and Trade Union colleagues to act as critical friends and help to promote and champion this work.

2. Official Launch – Late March / Early April *(diary hold dates to be circulated following approval)*

The official launch aligns with the International Day for the Elimination of Racial Discrimination (21st March 2026), making connections with our 2026 Diversity Calendar and Staff Stories initiative. Scheduling to be mindful of Eid and key religious dates and ensuring inclusive timing. Also ensure that we have launch events that are accessible for community and out-of-hours colleagues. Key activity includes:

- Launch event (hybrid or recorded element where possible) with board, senior leadership, staff, community and patient representation.

- Publication of a clear ‘What this means for you’ summary for colleagues and patients.
- Coordinated internal and external communications, including social media, press (where applicable), and website, poster and video updates.
- Linked to celebration events that show appreciation for our diverse workforce and local communities and the power of inclusion, especially within what can be a challenging societal context where we are seeing an increase in discriminatory behaviours and opinions.

3. Engagement and Roadshow – April onwards

Sustained engagement is vital to enable us to make the shift from awareness and promotion into action and implementation. Key activity includes:

- Roadshow sessions across sites and community venues, with the support of external partners.
- Targeted engagement with staff groups, patient forums, and community organisations.
- Collaboration and co-production with the Staff Ethnic Diversity Network, third sector partners and faith centres.
- Use of face-to-face sessions, posters, videos and easy-read materials to mitigate digital exclusion and enhance reach. Translated documents where appropriate.
- Linking with key strategic pieces of work to ensure interconnectedness and joint working such as Population Health and Care Strategy and Values Based Health and Care Strategy.

What Communications Channels and Formats will we utilise?

- **Digital**: Intranet, staff brief, website, QR codes, social media (with support from Communications colleagues).
- **Non-digital**: Posters, printed summaries, team brief packs, face-to-face briefings and attendance at meetings or events.
- **Accessible formats:** Easy-read, translated materials, video explainers, community languages where appropriate.

How will we know we’re reaching people?

- Staff awareness and engagement feedback.
- Attendance at events and roadshows.
- Social media reach and engagement.
- Qualitative feedback from staff network, patients and community partners.

NHS Forth Valley

Forth Valley NHS Board

9. Robotic Assisted Surgery in NHS Forth Valley
Purpose: This report is for Decision

Executive Sponsor: Andrew Murray, Medical Director
Author: Dr Julie Christie, Associate Medical Director, Women, Children & Sexual Health

Executive Summary

NHS Forth Valley currently provides complex cancer surgery in Colorectal, Gynaecology and Urology using traditional laparoscopic surgery. Most other Health Boards now have access to Robotic Assisted Surgery (RAS), which offers an enhanced view, access and precision, resulting in improved patient outcomes.

RAS offers improved visualisation, with enhanced illumination techniques, resulting in reduced blood loss and nerve sparing. The articulated instruments are held by the robot but controlled by the surgeon from the adjacent console. This removes unintentional human tremor, improves fluidity of movements, resulting in reduced operative time and complications, and allows better access to the deep pelvic anatomy. These advances have clearly demonstrated improved outcomes for patients, resulting in less morbidity, reduced post-op pain, shorter length of stay and a faster return to baseline function.

There is also less spend due to lower complications, fewer conversions to open surgery, less need for ICU admissions, reduced post-op imaging or return to theatre and a lower rate of readmissions. There are also some true savings with less analgesia used.

This generates significant cost avoidance by reducing complications, thus hastening recovery and freeing up bed days. It is estimated that the annual cost avoidance for NHS FV would be £0.5m per year, with 605 days released once fully operational. These 1.9 extra beds daily could help to improve whole system flow and unscheduled care performance, reduce elective waiting times, or generate income through mutual aid.

RAS is also better for our surgeons due to improved ergonomics, resulting in less fatigue and injury and increasing the longevity of our surgeons.

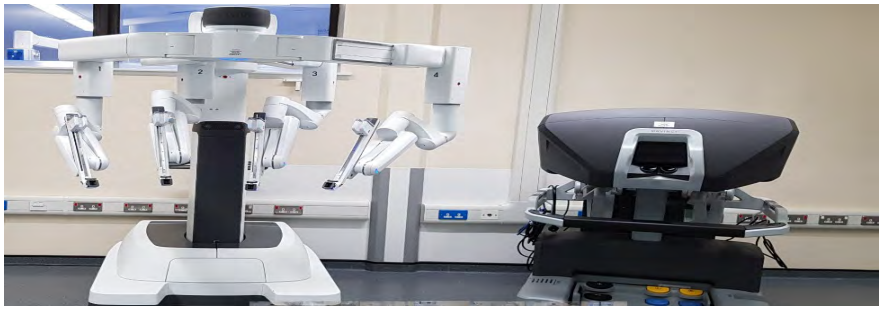

Image 1 – Da Vinci Xi Robotic system (left) and surgeon console (right).

By Jan 2025, Scotland had performed over 10,000 cases. This has now become “business as usual” rather than innovative.

In April 2025, NICE approved 5 robotic systems and is now formally evaluating the cost effectiveness.

In June 2025, the UK Government committed to increase access to RAS to >90% by 2035, versus 20% currently.

NHS Forth Valley is one of 3 mainland Health Boards in Scotland who do not have a robotic system. There is therefore a risk that if this isn't addressed, then these NHS Boards are at risk of being left behind, which could lead to inequities in patient care and outcomes. It could also make the future recruitment and retention of surgeons, anaesthetists and theatre teams more challenging and impact on long-term workforce stability.

There are currently 2 trained RAS Colorectal surgeons in Forth Valley and a 3rd who is partially trained. There are 2 identified Gynaecologists and one Urologist, who are all performing advanced laparoscopic cancer surgery. These would be the initial surgeons trained, who would perform mostly cancer surgery, before introducing some benign work and additional surgeons to fully utilise the investment. The recommendation is to have a max of 7-8 surgeons per system. This allows a select few to gain expertise quickly and have regular access to further refine their skills.

There is a very robust training programme, with sign off at every stage and strict governance would be in place to monitor performance and outcomes.

Four options were considered. Option 1 described the status quo where our colorectal patients have no access to RAS. Option 2 was to send patients to other centres for surgery but there is currently no capacity to do this. Option 3 was to send our surgeons and patients to other centres to perform RAS but again is limited by capacity and cost. Option 4 was to purchase our own robotic system.

Purchasing our own Da Vinci Xi dual console robotic system was the most cost effective and deliverable outcome. This will provide equitable care for our patients, optimising outcomes, using value based technology which is in line with the principles of the new Population Health and Care Strategy 2025-2035 by reducing inequality, delivering care closer to home and developing our workforce.

Action Required

The Forth Valley NHS Board

1. note that Board members have had a number of opportunities to provide feedback and influence in shaping the Robotic Assisted Surgery proposal detailed in the Route to the Meeting to ensure that appropriate assurance has been provided;
2. note the associated financial implications in terms of anticipated capital and revenue costs and funding sources.
3. approve the acquisition of a Robotic Assisted Surgery (RAS) system as set out in the Business Case;
4. consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration
This matter has previously been considered as part of its development as set out below. Board Members have had a number of opportunities to comment, seek and gain further assurances.

- Senior Leadership Team - March 2025. Case updated to focus on multispecialty surgery to maximise utilisation.
- Senior Leadership Team - October 2025. More in depth review of recurring costs undertaken.
- Strategic Planning, Performance and Resources Committee - 16 Dec 2025
- Submission of written comments and further assurances required by Board Members - December 2025. Finance section updated
- Submission of written comments and further assurances required by Board Members on revised Business Case - January/February 2026.
- Board Seminar - 10 February 2026 – an opportunity to provide Board members with assurances on further information sought and any final considerations before the Business Case is submitted to the Board for decision.

Risk Assessment and Mitigation
Risks to patients – Patients are now very aware of RAS technology and are actively seeking this type of surgery. Currently colorectal patients within NHS Forth Valley have no access to RAS surgery, which has improved outcomes and lower complications. Patients with high-risk gynaecology cancers have limited access to RAS surgery in Glasgow. In urology, patient with bladder and prostate cancers have access in Lanarkshire and A&A. Patients with renal cancers have laparoscopic surgery locally.

Some patients have already requested transfer to other sites to have RAS procedures. This may increase. There currently is no capacity elsewhere for our patients or surgeons to travel to another Health Board to offer this.

We do currently offer safe, advanced laparoscopic surgery to these cancer groups, but analysis of our own data has demonstrated significant benefits to patients using RAS techniques. This modelling predicts lower conversions, complications, critical care admissions, blood transfusions, post-op imaging requirement, analgesia, return to theatre and readmissions.

Risks to surgeons – Laparoscopic surgery often results in neck and shoulder injuries and is more challenging in patients with high BMI. RAS surgery removes this risk as the surgeon operates from a console, without any physical strain. Surgeons currently try to avoid fatigue and will only do one complex case per day. The number of major cases per day would increase once fully established RAS techniques are embedded.

Risks to recruitment and retention of staff – RAS surgery is now expected as normal, and many trainees have already experienced this in other Boards. There is a risk that existing surgeons may leave and vacancies may become difficult to fill without RAS access. As a District General Hospital, we need to be seen as a desirable centre to work in, to help attract and retain staff. Having surgical vacancies would

impact on our ability to provide the level of on call cover required and result in increased locum spend.

Risk to reputation – NHS Forth Valley is only 1 or 3 mainland Boards in Scotland without a robotic system, despite delivering complex cancer surgery. NHS Dumfries & Galloway are already progressing with their Business case.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required X

Financial, Digital and Infrastructure Implications

The capital and revenue financial consequences of the preferred option are summarised below:

Capital Costs

Capital costs are estimated at £2.6m to purchase the robot and carry out the necessary local decontamination upgrades.

Scottish Government have confirmed that they will provide an additional £2.5m in capital funding through the National Infrastructure Board. The balance of £0.1m will be funded through our local capital formula allocation.

Non-recurring Revenue Costs

Initial non-recurring revenue costs of £0.3m in respect of initial instrumentation, staff training and temporary outsourced decontamination costs will be met through existing minor works budgets and other non-recurring funding allocations.

Recurring Revenue Costs

Net additional recurring revenue costs have been quantified at approx. £0.6m p/a. This is based on an upper limit estimate of £1.5m p/a in respect of new costs from additional staffing requirements (ASDU / Medical Physics), maintenance contracts, consumables, software costs and depreciation, partially offset by expected savings of £0.9m p/a from theatre staffing, laparoscopic instruments and other recurring budgets.

Additional non-recurring revenue funding of £0.5m has been confirmed from Scottish Government to meet running costs in the first year of operation (2026/27). Future year revenue costs from 2027/28 have been included in the NHS Board Financial Plan.

A recurring funding source will be identified before 31st March 2027, based on evidence of actual costs incurred in the first year of operation, focusing on cash releasing service efficiencies and prioritising contribution from wider cost savings initiatives where required.

Future cost avoidance

Predictive modelling based on local surgeons' data suggests there will be a cost avoidance annually of £0.2m due to a reduction in complications, readmissions and conversions. In addition, 695 bed days would be released per year. If this reduction in length of stay is also included, this shows a total cost avoidance of £0.5m annually. These extra 1.9 beds each day could increase bed capacity to help with unscheduled flow, reduce waiting times or support mutual aid.

Workforce Implications

All staff members involved are excited and enthused about the idea of getting a robotic system into Forth Valley. This will ultimately allow teams to deliver the best outcomes for patients, whilst allowing the staff to develop new skills and ways of working, with a dedicated multi-specialty robotic theatre team, which improves patient safety, training opportunities for medical and nursing staff, and overall will boost staff wellbeing.

With a dedicated theatre team and SFA, the nursing model for the theatre team can be reduced by 1 WTE band 3.

The ASDU team are already at capacity due to increased processing of theatre equipment through Waiting List Initiative workload over the last few years. Introducing RAS will not generate additional theatre cases, as it will replace existing laparoscopic cases. However, additional staff will be required as the processing steps for RAS are different.

There would be an increase in ASDU by 1 WTE band 3 and 0.8 WTE band 4 once local processing starts. This would be kept under close review. Additional staffing in Medical Physics of 0.2 WTE band 6 is also included in the business case.

Quality / Patient Care Implications

There is clear evidence that RAS produces better outcomes for patients with a faster recovery to baseline function. Robotic surgery is the next step of minimally invasive techniques. The cancer patients, who currently have laparoscopic surgery, will have RAS surgery instead. These numbers will stay the same. This will not have any negative effect on waiting times.

There may be a small group of patients who would ordinarily be considered unfit for conventional laparoscopic surgery, who will now be able to be offered this technique as the lower abdominal pressures cause less physiological strain for the patients.

Once the surgeons have built up their experience, they will be able to perform the surgery faster which will allow more cases per list, improving efficiency.

Some benign cases are also suitable for RAS and several Health Boards have used this model to offer high volume, rapid turnover of cases to reduce their waiting times. E.g. Day case hysterectomies in A&A, 5 per day.

Population Health & Care Strategy
The recently published Population Health and Care Strategy for 2025-2035 describes **reducing inequalities** and delivering **care closer to home**. Currently many of the cancer patients in Forth Valley are offered a different treatment than patients elsewhere due to lack of robotic access. With our own system, these patients would be offered equal care to others.

Cancer incidence and prevalence are higher in socioeconomically deprived groups, particularly men with colorectal cancer. This is due to a lower uptake of screening and later stage at diagnosis, contributing to more complexity and poorer outcomes. RAS access will lead to a more significant improvement in their outcomes both locally and regionally.

Once established, there may be future potential to repatriate cases such as prostate cancer, which would allow patients to have their care closer to home, generate significant savings and lead to improvements in the 62 day performance.

This purchase would also **develop our workforce** and make NHS Forth Valley a more attractive place to work, which would enhance retention and recruitment of staff.

There is a fantastic example of **value based** practice and NICE are currently undertaking a formal analysis of the cost benefits of RAS.

Climate Change / Sustainability Implications
Laparoscopic cases require higher levels of intra-abdominal pressure to access the pelvis, so use more carbon dioxide (CO2) per case to inflate the abdomen. RAS allows surgeons to operate with lower pressures, as the robotic arms lift the abdominal wall. The operations are also shorter, thus reducing the CO2 used per case.

Having our own RAS system would reduce the need for patients or surgeons to travel out with Forth Valley for surgery, thus reducing the carbon footprint.

The majority of staff training would be in-house, so minimal travel would be required.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes X No ☐

- Invites to interested surgeons, anaesthetists and theatre teams were sent, with responses allowing identification of the initial surgeons to train. Maximum 7-8 per robotic system.
- Anaesthetists with previous experience have also nominated themselves
- Theatre and recovery teams have expressed enthusiasm and volunteers for a dedicated multi-specialty theatre team have come forward, including 2 surgical first assists (SFAs)

Appendices
Appendix 1 – Final RAS Business case Feb 2026
Appendix 2 – Predictive Value for Money Modelling for NHS Forth Valley

Business Case: Robotic Assisted Surgery in NHS Forth Valley

Striving to provide equitable, safer, value-based care

Version	**6**
Date	**06/02//2026**
Authors	**Dr Julie Christie - Associate Medical Director, Women, Children and Sexual Health** **Mr Akan Emin - Clinical Director General Surgery** **Ellen Davidson – Finance Manager** **Pia Kelly – Senior Finance Business Partner**
Contributors	**Ann Laidlaw - Acting Service Manager for; Theatre, Anaesthetics, Day Surgery Unit & Pre Assessment** **Morna Bechelli - Acting Operational Manager for; Theatre, Day Surgery Unit & Pre Assessment** **Michelle Forsyth - ASDU** **Graeme Crow - ASDU** **Bryan Hynd - Medical Physics** **Chris Cairns - Associate Medical Director, Surgery and Anaesthetics** **Scott Jaffrey - Director of Digital** **Helen Sutton – Senior Finance Business Partner**
Updates	**Version 6** **Financial case outline – within Executive Summary** **Finance - section 6,7,8 and appendix.**

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Section	Purpose of document
	Executive Summary
1.	Establish the Need for Change (the case for change)
2.	Establish Strategic Context
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4.	Generate Options
5.	Scoring of Options against Benefit Criteria
6.	Economic appraisal
7.	Financial appraisal
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9.	Risk
10.	The Preferred Option
11.	Benefits Realisation Plan
12.	Sustainability Implications
13.	Equal Opportunities / Equality Impact Assessment
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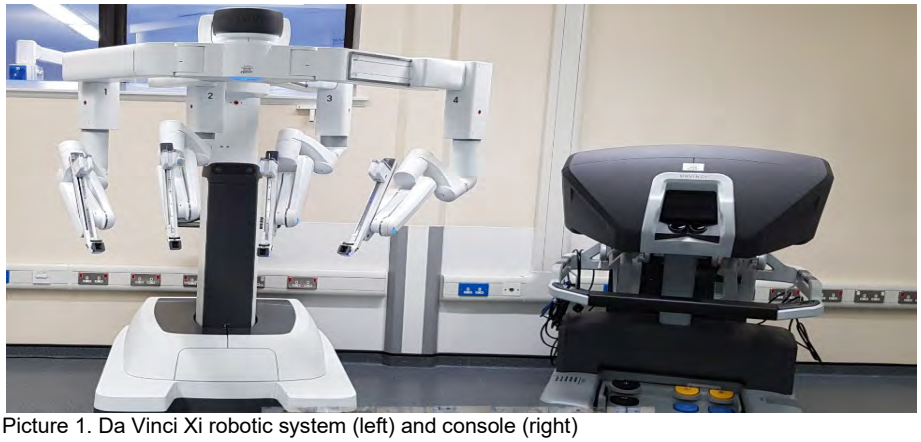
Executive Summary

Introduction of Robotic Assisted Surgery in NHS Forth Valley

NHS Forth Valley currently provides complex cancer surgery in Colorectal, Gynaecology and Urology using traditional laparoscopic surgery. Many other Health Boards now have access to Robotic Assisted Surgery (RAS) which offers superior surgical access resulting in improved patient outcomes, with less morbidity, reduced post-operative pain, shorter length of stay and a faster return to normal activity.

Using RAS technology therefore improves operational efficiency and cost effectiveness via reduced length of stay and increased patient flow.

RAS is also ergonomically better for surgeons, resulting in less fatigue and musculoskeletal issues.



Picture 1. Da Vinci Xi robotic system (left) and console (right)

By Jan 2025, Scotland had performed over 10,000 RAS cases. This has now become “business as usual” rather than innovative in most Boards. In April 2025, NICE approved 5 robotic systems and is formally evaluating the cost effectiveness.

In June 2025, the UK Government committed to increase access to RAS to >90% by 2035, versus 20% currently.

NHS Forth Valley is one of 3 mainland Health Boards in Scotland who do not have a robotic system due to an initial regional agreement within the West of Scotland that committed to access to RAS for Forth Valley patients in other Health Boards. Due to operational issues this has not been delivered and therefore NHS Forth Valley now requires its own RAS to provide access to this superior technique for Forth Valley patients.

There are currently three trained or partially trained RAS Colorectal surgeons in NHS Forth Valley. In other specialities, there are two Gynaecologists and one Urologist who would be trained and would perform mostly cancer surgery before introducing complex benign surgery to fully utilise the investment. The recommendation is to have a max of seven surgeons per system. This allows a select few to gain expertise quickly and have regular access to further refine their skills.

There is a robust training programme, with sign off at every stage and strict governance in place to monitor performance and outcomes. This is critical to mitigate against low volume surgeons using the RAS and not being able to deliver the anticipated benefits, thereby nullifying the investment.

During the development of this recommendation, four options were considered. Option one described the status quo where our colorectal patients have no access to RAS. Option two is to send patients to other centres for surgery but there is no operational commitment from other Health Boards to deliver this and this is therefore one of the main drivers for NHS Forth Valley to acquire its own system. Option 3 is to send surgeons and patients to other centres to perform RAS but again is limited by neighbouring Health Board's engagement. Option 4 is to purchase our own robotic system.

Purchasing our own system, most likely the Da Vinci Xi dual console robotic system, is the preferred option. This will provide equitable care for our patients, optimising outcomes, using value based technology which is in line with the principles of the new Population Health and Care Strategy 2025-2035. By providing this surgery in NHS Forth Valley, it also delivers care closer to home and develops our workforce.

National Procurement is working with the National Infrastructure Board, who have funded the capital purchase of Robotic systems in all other Health Boards, including any infrastructure capital costs. It is anticipated that the purchase of a robotic system for NHS Forth Valley would also be funded nationally towards the end of this financial year.

The costs for NHS Forth Valley to be fully sighted on are the recurring consumable costs which are similar to those for laparoscopic surgery, the technique surgeons currently use for these types of operations, with the added benefits of reduced length of stay and improved patient outcomes.

Financial Case Outline

Capital Costs and Funding

The preferred option and procurement route is to is to directly purchase a robotic system (ie option D3). This would require £2.6m in capital funding to buy the robot and carry out the necessary local decontamination upgrades.

The Scottish Government have confirmed that they will provide an additional £2.5m in capital funding through the National Infrastructure Board (NiB). The balance of £0.1m will be funded through our local capital formula allocation.

Revenue Costs and Funding

Net additional recurring costs have been quantified at approx. £0.6m per annum (see finance table Option D3 - page 53). This is expected to be at the upper end of cost estimates and factors in an optimism bias cost.

Additional revenue funding of £0.5m has been confirmed from Scottish Government to meet running costs in the first year of operation (2026/27). Future year revenue costs from 2027/28 have been included in the NHS Board Financial Plan.

A recurring funding source will be identified before 31st March 2027, based on evidence of actual costs incurred in the first year of operation, focusing on cash releasing service efficiencies and prioritising contribution from wider cost savings initiatives where required.

Whilst the robot will generate positive productivity efficiencies and future cost avoidance, those benefits are unlikely to translate into cash releasing savings in the short term.

Key metrics are summarised below:

- The capital cost of the preferred option is estimated at £2.6m (£2.5m of which will be funded by the Scottish Government).

- The net additional recurring revenue cost of the preferred option has been quantified at an upper limit of c£0.6m per year.

- Scottish Government has confirmed revenue funding of £0.5m to meet revenue costs in the first year (2026/27). Future year recurring costs have been factored into the NHS Board's financial plans and a recurring funding source will be identified during 2026/27 to be in place by 31st March 2027.

- Total recurring cost avoidance of just under £0.5m annually is estimated due to reduction in length of stay (estimated at 695 bed days released per year or 1.9

beds every day).

- The estimated cost per RAS case is similar to laparoscopy cost per case. There is potential to not replace one endoscopic stack along with associated microscopes and peripherals when they come to end of life and thus saving on associated maintenance costs.
- £1,000 cost avoidance per case is estimated due to reduced complications, reduced critical care usage, reduced analgesia, shorter stay, fewer readmissions, fewer open procedures
- There is potential for Income Generation: through training proctorship once surgeons reach mastery and potential mutual aid capacity to treat patients from neighbouring health boards.

There are risks with further delay in RAS acquisition.

- Increased patient transfers to other Boards with rising costs
- Reputational risk: perception of outdated care
- Potential loss of colorectal, urology and gynaecological cancer cases
- Recruitment vulnerability: inability to attract or retain RAS-trained staff

This paper provides support for the **recommendation** to procure a RAS system, most likely the Da Vinci Xi Dual Console RAS system to deliver:

- Equity of access
- Better outcomes for patients
- Better for surgeons with reduced fatigue
- Better recruitment and retention
- Long-term service sustainability

1. Establish the Need for Change (the case for change)

This business case aims to secure national funding to support the introduction of robotic assisted surgery (RAS) at NHS Forth Valley. This will provide equal access for our patients to undergo safer cancer surgery, with less complications, faster recovery and a shorter length of stay, with resulting cost avoidance.

Robotic Surgery was first introduced in Scotland in 2015 in NHS Grampian for urology. It was considered an innovation in minimal access surgery, allowing the surgeon to operate with greater precision, thus reducing complications and improving patient outcomes, due to the articulation of the instruments and improved vision. The patients received safer surgery, with faster recovery, shorter length of stay, and rapid recovery to baseline function. The surgeons suffered less fatigue and repetitive strain injury, thus improving morale, longevity of the workforce, and enhanced recruitment and retention.

In the last 5 years, the Scottish Government, NHS Procurement and the National Infrastructure Board have approved the use of robotic assisted surgery (RAS) platforms for treatment of cancer across the breadth of Scotland. This technique has moved from being considered “innovative” to being accepted as “business as usual”. The significant health benefits to patients and surgeons alike have been well evidenced, and the cost avoidance clearly demonstrated.

In June 2025, Wes Streeting, UK Health Secretary, who himself has undergone a RAS partial nephrectomy for renal cancer, proposed that Health Boards in England not adopting this technology, will receive lower tariffs per theatre cases than those who perform robotic assisted surgery. There is a plan to significantly expand RAS use so that by 2035 more than 90% of keyhole surgery will be performed with robotic assistance versus the 20% currently.

NHS Forth Valley is now only 1 of 3 mainland hospital Boards who do not have a robotic system, despite performing major cancer surgeries in colorectal, urology and gynaecology patients.

Previously, RAS systems were mainly used for treatment of prostate cancer in urological surgery where surgeons operate deeply in the pelvis. The same techniques also offer benefits to colorectal surgery and gynaecology, especially when operating on obese patients.

This initial NHS procurement process sought the provision of RAS systems to high volume centres expediting colorectal cancer, gynecological cancer and urological cancer amongst other specialties[1]. However, the benefits were recognised quickly and smaller centres were also given the opportunity to benefit from RAS surgery.

There has been a significant expansion to RAS in Scotland since 2021. Phase 1 was to allow all patients access to RAS surgery for cancer of the prostate, kidney (nephrectomies), bowel (colorectal) and uterus (endometrial).

The table below shows the current allocation of robotic systems across Scotland, purchased by the National Infrastructure Board with input from the national procurement process. There are also now robotic systems in the Spire in Edinburgh and Ross Hall in Glasgow offering RAS surgery privately by NHS surgeons.

Table 1: RAS systems in NHS Scotland July 2025

Health Board/Institution	Number of RAS systems	Specialties involved in RAS surgery
NHSGG&C	GRI RAS = 1 QEUH RAS =2	Gynae/Colorectal Urology/Colorectal/ ENT
NHS Golden Jubilee	Golden Jubilee RAS = 2	Colorectal/Thoracic/General hernia/ abdominal wall
NHS Lanarkshire	University Hospital Hairmyres RAS = 1	Colorectal/Gynae/Urology
NHS Highlands	Raigmore Hospital Inverness RAS = 1	Colorectal/Gynae/Urology/UGI
NHS Fife	Kirkcaldy Hospital RAS = 1	Colorectal/Gynae/Urology
NHS Tayside	Ninewells Hospital, Dundee RAS = 1	Colorectal/Gynae/Urology/ENT
NHS Lothian	Edinburgh Western General RAS =1 E R Infirmary RAS = 1 St John's RAS=1	 Colorectal/Urology Gynae/UGI/Thoracic Gynae/Urology/ENT
NHS Grampian	Aberdeen Hospital RAS = 2 3rd decommissioned as old	Urology have 1 system 2nd shared Colorectal/Gynae/ENT/HPB/ Bariatric Also orthopaedic RAS
NHS Ayrshire and Arran	Crosshouse Hospital RAS = 1	Colorectal / Gynae/ Urology

NHS Forth Valley, NHS Dumfries and Galloway and NHS Borders are now the only 3 mainland Boards without a robotic system, which means our patients are not receiving equitable care.

NHS Forth Valley already has 2 fully trained RAS colorectal surgeons performing approx. 120 cancer surgeries per year, between 3 surgeons. The third surgeon has also started training. There are also advanced laparoscopic surgeons in urology and gynaecology performing cancer surgery, who have patients who would also benefit from this investment.

There is a robust training schedule for the surgeons and theatre team, with strict governance processes to ensure compliance and patient safety.

Once surgeons reach the mastery stage with over 100 cases, they can become proctors. Should observers visit the hospital site to see their surgery, income generation of approximately £1750 per visit is possible. The simulation centre may also consider running robotic theatre team training courses.

There is significant cost avoidance using RAS, over open or laparoscopic surgery, resulting in a shorter length of stay. This extra bed capacity could be used to further reduce our waiting times, allowing more capacity for mutual aid.

Savings have also been demonstrated due to requiring less post-operative diagnostic investigations and less analgesia.

NHS Forth Valley currently provides a high standard of care for colorectal cancer and has good outcomes[2]. However, with no current access to RAS for these patients, this has highlighted inequalities in care. Some patients have requested care in other areas to access this technology.

Prostate and bladder cancer patients are offered RAS in GG&C. However, those requiring nephrectomy have this done laparoscopically in NHS Forth Valley.

In Gynaecology, more aggressive cancers are sent to Glasgow Royal Infirmary for RAS access, but the rest have laparoscopic or open hysterectomies.

Cancer is associated with obesity, which makes laparoscopic surgery more challenging, but RAS benefits the patients and the surgeons, especially in cases with high BMI.

This business case aligns with the strategic objectives of NHS Forth Valley Procurement, specifically Strategic Objective 2 “Continuous Improvement and Innovation”. It also aligns with the NHS Forth Valley Healthcare Strategy 2021 by “attempting to tackle health inequalities and provide person centred care”, as well as “providing care closer to home”[3]. The most recent Population Health and Care Strategy for 2025-2035 also promotes reducing inequalities, providing care closer to home, developing workforce, and providing value-based care. RAS fits into all of these categories.

The 3-year plan would start with RAS in Colorectal, with the 2 trained surgeons, before expanding to include a 3rd colorectal surgeon, 1 in Urology and 2-3 in Gynaecology for cancer cases and complex benign in year 1-2.

This will also allow us to recruit and retain highly skilled surgeons, anaesthetists and theatre teams in the longer term. It will bring our hospital in line with others who have already embraced this technology, recognising the benefits to patients, staff, and finance. Most importantly, this service will be sustainable and cost-effective in the long term.

Open vs Laparoscopic vs Robotic Surgery

Sir Professor Alfred Cuschieri performed the first laparoscopic cholecystectomy (gallbladder removal) in 1987 in Ninewells, Dundee, Scotland heralding the introduction of minimal access surgery. Traditional laparoscopic surgery (keyhole) uses CO2 gas to inflate the abdomen to high pressures, with the patient in a steep head down tilt to move the bowel away, thus allowing access to the pelvis. Straight stick instruments are passed through the abdominal wall ports to perform the surgery. It requires at least 2 surgeons per case to control the camera and assist the operating surgeon. The movements of these instruments are restricted by the thickness of the abdominal wall, the shape and depth of the pelvis, and the reach of the surgeon and instrument.

These cases can last several hours resulting in neck and shoulder fatigue for the operating team due to the ergonomics required for surgery. The patients also have significant pain post operatively due to abdominal wall shearing and steep head down tilts required for surgery. However, laparoscopic surgery offers significant benefits and faster recovery when compared to open surgery with large laparotomy wounds.

In contrast, during robotic-assisted surgery, once the ports and instruments are inserted, they are attached to the robotic arms. These help to lift the abdominal wall, thus allowing the surgeon to operate under lower abdominal wall pressures and with less head-down tilt. This causes less physiological stress to the patient and allows patients, who would otherwise be unfit for traditional laparoscopic surgery, to have surgery. This offers better outcomes for more of the population.

The instruments are articulated at the end, allowing a full range of movement like a wrist. The flexibility of the instruments allows the surgeon to access the pelvis more easily and therefore reduces the abdominal wall forces needed in traditional keyhole surgery. This results in less post-operative pain and a faster recovery.

The camera and the instruments are always controlled by the operating surgeon, from a console separate from the operating table, where they are immersed with a 3D pelvic view. The robotic arms hold these instruments thus removing any fine tremor found with a human assistant, resulting in more precision. As the surgeon controls both the camera and instruments, this results in more fluent surgery. The enhanced vision, with firefly illumination to highlight anatomical structures, aids more accurate dissection, with less blood loss, nerve sparing, and reduced complications. The surgeon operates whilst sitting in a console, which reduces surgeon fatigue and injury and communicates with the rest of the theatre team via a microphone.

The dual console allows another surgeon to observe or be taught to operate. The Royal College of Surgeons and Royal College of Obstetrics & Gynaecology have now published robotic training programmes for doctors in training, as this is now accepted as the norm. Many of our current trainees already have robotic experience.

The robot can improve upon traditional open and laparoscopic surgery in several ways:

- RAS allows better 3-dimensional visualisation utilising a static camera controlled robotically.
- Robotically controlled instruments reduce tremor.
- The improved handling of tissues speeds up the performance of complex surgical procedures in difficult to access areas, such as the pelvis and retroperitoneum, as well as complimenting the safety aspect of the procedure.
- The improved ergonomics and reduced operating times lead to less operator fatigue and reduced incidence of repetitive strain injury, which is a recognised problem with laparoscopic surgery.
- The technology allows the learning curves of complex procedures to be shortened (compared with standard laparoscopy), leading to reduced operating time and improved outcomes earlier in the adoption process.
- It provides up to date training facilities for surgical trainees

All the above translate into improved clinical outcomes, with more cost-effective use of the limited human and operating theatre resources available. For patients, this means improved functional outcomes, minimal blood loss (and associated blood transfusions), decreased length of hospital stay (LoS), less post-operative pain and quicker return to normal activities.

Many anaesthetists have also experience of working with robotic surgery and can see the benefits to the patients, with less physiological strain during the surgery, reduced opioid requirements post op, and lower critical care demands.

Picture 1. Da Vinci X1 robotic system on left, with the surgeon console on right

Picture 2. Dual surgeon operating from consoles

Evolution of the Surgical Model

The surgical model of care has transformed over the last few decades with the shift from open surgery to less invasive laparoscopic surgery from 1987 and is now transitioning to RAS being the expected standard of care, due to the improved clinical outcomes and financial benefits.

The uptake of RAS systems has been increasing across the UK and most recently in Scotland. This trend reflects safe and effective implementation of robotic surgery, replacing laparoscopic, and open surgery. This broadens the access to minimally invasive surgery and its benefits, to a wider population of patients, with complex high-risk problems, such as obesity and previous surgery.

Complex rectal cancer, especially in obese male patients with narrow pelvis', are particularly challenging via the laparoscopic approach, due to the inability of laparoscopic instruments to articulate within the pelvis and therefore cannot negotiate the curvature of the pelvis. Currently this procedure is performed laparoscopically, if possible, with high chance of conversion to open. Robotic surgical platforms reduce the rate of conversion of such cases[4].

Robotic surgery was first used for Urology and Thoracic surgery, but this advanced technology also offers benefits in Gynaecology, ENT, and Upper GI patient groups.

2. Establish Strategic Context

2.1 Forth Valley Demand and Capacity

Over the last 2 years, there are approx. 100 cases per year for colorectal cancers requiring surgery. These include the procedures listed in the table below. At present, these patients are being offered only laparoscopic or open surgery, whereas others across the country undergo RAS procedures. GRI RAS data have shown a reduction in length of stay from 6 to 4 days. This is what NHS Forth Valley would be targeting.

Table2. Data source: FV report searched and data pulled on description of procedure.

Colorectal Procedures	**2021**	**2022**	**2023**	**2024**
Right Hemi Colectomy & Anastamosis	74	40 (66)	46	54
Left Hemi Colectomy & Anastamosis	8	3 (9)	6	7
Sigmoid Colectomy & Anastamosis	26	22 (30)	24	8
Anterior Resection of rectum & Anastamosis	27	48 (15)	31	25
Abdominoperineal excision of rectum and end colostomy	8	9 (2)	5	1
Panproctocolectomy	5	3 (6)	5	2
Total	**148**	**125 (128)**	**95**	**97**

For Gynae, QPIs for 23-24 showed there were 52 endometrial cancers diagnosed and 38 operated on in total. Some were sent to Glasgow to have RAS surgery for sentinel node removal. In addition to the known cancers, hysterectomies were also performed for 12 cases of atypical hyperplasia, 6 for CIN 3 premalignant conditions.

Other Gynae oncology cases include prophylactic removal of ovaries (bilateral salpingo-oophorectomies BSO) for those who have the BRCA gene mutation, putting them at higher risk of breast and ovarian cancer. So, the gynae oncology team would expect to perform approx. 40 RAS hysterectomies per year and approx. 20 Lap BSO. Not all the BSO would need RAS surgery, but other suspicious fibroids or complex ovarian cysts who currently have laparotomies (open surgery) would benefit from RAS instead.

Benign complex endometriosis patients would also benefit from RAS techniques to help safely dissect scarred tissue planes during resection of the disease. These patients make up a high proportion of our longest waits and are being highlighted in the Women's Health Plan.

Table3. Gynae hysterectomies

Procedures	1/7/24-18/7/25
Total Laparoscopic Hysterectomy	86
Total abdominal Hysterectomy (open)	52
Vaginal Hysterectomy - prolapse	7
Total	145, of those 117 suitable for RAS

For Urology, currently the bladder and prostate cancers go to NHS Lanarkshire and NHS Ayrshire & Arran for RAS access. The renal cancers have laparoscopic surgery locally.

Table 4. Urology Data

Procedures	2023	2024	Aug 2025
Prostatectomy cancer	115	68	51
Cystectomy (bladder cancer)	8	10	7
Nephrectomy (kidney cancer)	27	30	31

It is recommended that each RAS surgeon performs 50 cases per year. There are approximately 30 renal cancers per year, but there are other benign urology cases that could also be performed robotically to fully utilise the session.

Ideally, there should be 2 surgeons per specialty, so there may be a case in the future to consider bringing the prostates cases back to Forth Valley if we recruit an appropriately trained surgeon. This would help reduce waiting times and improve the 62-day performance.

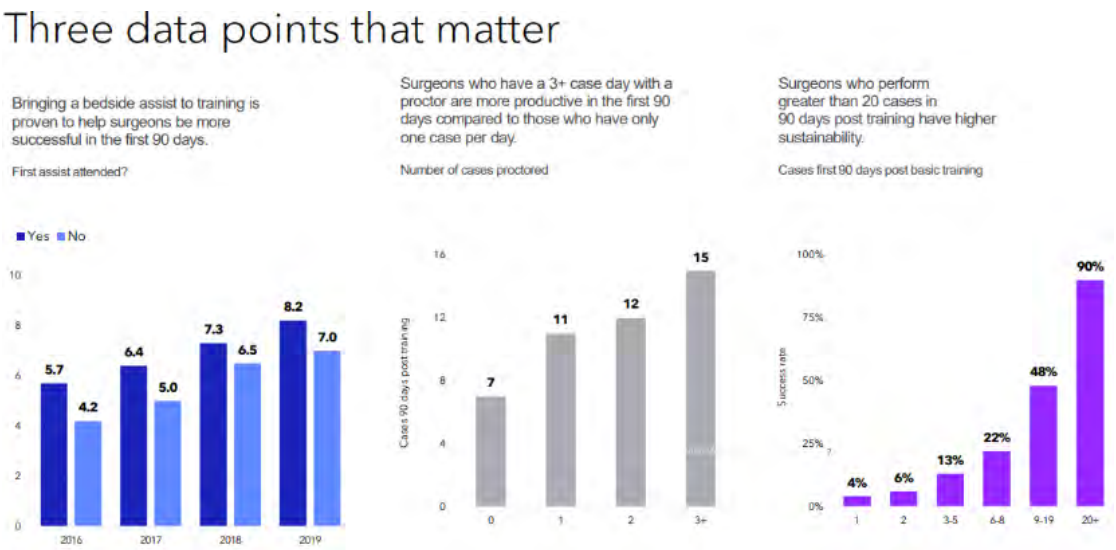
To Aug 25, there have been 259 Urology cases sent to GG&C for RAS procedures, 234 prostatectomies, and 25 cystectomies.

2.2 Projected Activity

There is a strict training schedule to be completed before operating on patients. It is recommended not to have more than 7-8 surgeons per system. All surgeons must demonstrate 30-40 hours on the simulator and gain >90% scores in all domains, before progressing to dry and wet lab training.

Initial operations are proctored and require sign off to confirm the surgeon is competent to operate independently. There is a recommended case mix in the learning phase to gain experience with RAS before progressing to more complex cases.

Surgeons who start with higher case numbers of short cases progress more quickly. Having a surgical first assist with every case also improves the overall efficiency of the team, rather than relying on the team doctor in training, who will not have the same exposure.

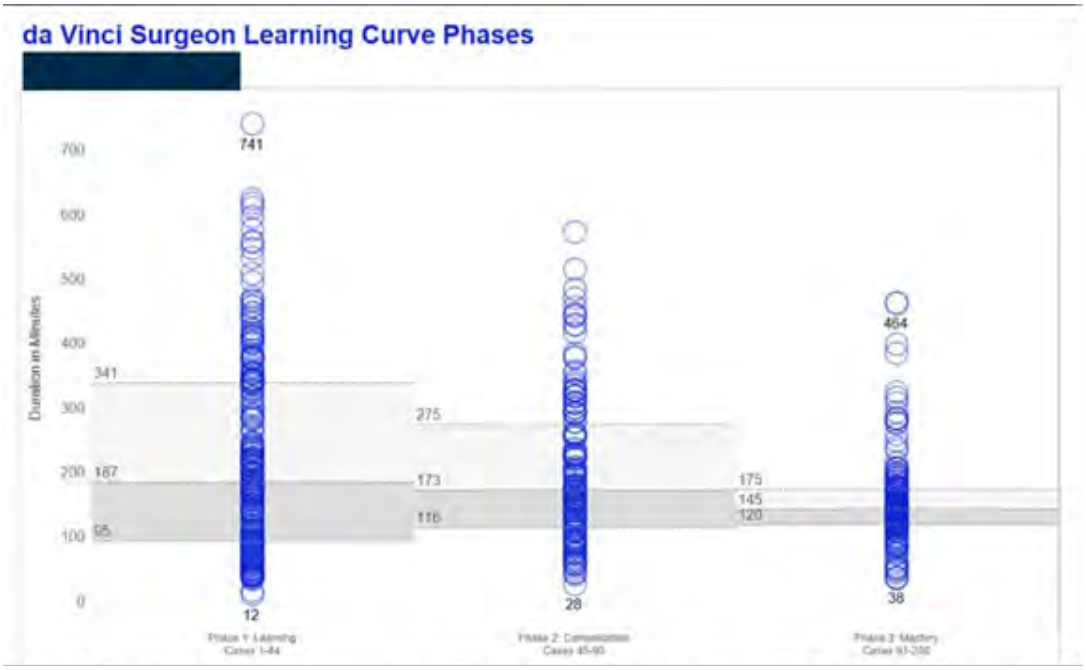


Picture 3 – training stages

By having a strict limit of the numbers of surgeons per system, this allows more sustained exposure which reduces the learning curve. There is guidance on which procedures to learn first, aiming to do shorter simpler cases to start, before progressing to more complex cases.

Surgical Skills	• 3-Arm Usage • Non-complex suturing • Appropriate instrument selection	• 4-Arm Usage • Tissue retraction • Surgical site exposure • Visual control of applied tissue force	• Instrument reach • Surgical site exposure • Complex suturing • Visual control of applied tissue force	• Surgical plane identification • Coordination of 3 instruments and assistant surgeon • Exposure in confined spaces • Tissue management
Recommended Procedure	Inguinal Hernia Repair	Cholecystectomy	Fundoplicatio	Sigmoid Resection

Table 4: The case mix to start initial training with before progressing to more complex cases.



Picture 5. Learning Curves from surgeons in Ninewells hospital demonstrating learning phase case1-44 consolidation 45-90 and mastery 91-200 cases.

The learning curve improves quickly with increased experience. The plan would be to start the colorectal team with 2 x 3 session days for the first 6 months, before moving to 3 x 2 session days. It is recognised that most lists would have a major resection plus an additional case, once initial training is completed.

The anticipated Forth Valley activity trajectory is as follows:

Table 5 –FV projected activity

Number of RAS cases	Year 1	Year 2	Year 3
Colorectal and general surgery	160	200	230
Gynaecology	30	100	120
Urology	10	50	50
Totals	200	350	400

Surgeons can be fully trained within 6 months. The initial aim is to have access for the 3 Colorectal surgeons, whilst the Gynaecology and Urology teams start training. As they are already advanced laparoscopic surgeons, they only need to learn how to use the equipment but already know how to perform the surgery. This should allow us to progress to over 300 cases within the first 2 years. Efficient use of the robotic system should achieve between 300-400 cases annually.

The specialties and case mix proposed for the NHS Forth Valley Robot are follows:

- Colorectal and general surgery (3 surgeons) will operate on around 120 cancers per year, once fully established. During initial training, though lower complexity cases will be done, increasing the overall case numbers. The cancer cases will start with the left side before progressing to sigmoid, then rectum.
- Gynaecology (2-3 surgeons) - initially we would expect 50 hysterectomies per year for cancer, but in year 2 this would expand to include complex endometriosis cases.
- Urology (1 surgeon) would perform RAS nephrectomies. These overall numbers are lower than recommended so would need to be kept under review. Consider future recruitment of 2nd RAS surgeon to perform prostatectomies and offer peer support.

The theatre schedule would start with 2 x 3 session days but then increase to 3 x 2 session days for General surgery, 1.5 days for Gynaecology and 0.5 days for Urology (alternate week full day) as training progressed.

2.3 Staffing impact

It is proposed that initially 3 Consultant Colorectal Surgeons will be trained in RAS in NHS Forth Valley. Two surgeons are already trained and have completed 25 RAS cases in total to date. A third surgeon will complete RAS training onsite. It is mandated that whilst both surgeons are ready to begin, they will still need to refresh their training modules and will require proctorship for their first few cases.

Gynaecology and Urology consultants will need to start training on the simulator on delivery of the system. They will need to evidence 30-40 hours on the simulator, gaining scores of >90% in all domains before progressing to the next stage.

Initial training involves 4 stages: Simulation, Observation, Wet-lab, and Mentored practice. This is followed by a period of practice and familiarisation until a surgeon is working at full capacity, and this typically takes 3 years. (Appendix 1&2 details the robotic training pathway)

Having a dedicated theatre team for robotic theatre and at least 2 trained surgical first assists (SFA), improves the safety and progression of the surgical practice. As the case numbers increase, it is anticipated that a 3rd first assist will be required. There are currently 2 SFA in post who have expressed interest in working within a robotic theatre.

The long-term plan will be to run 5 days per week with 2 session days, but in the early days, a 3-session day would be planned. Theatre recovery staff have offered to work flexibly to support this initial phase.

With a dedicated theatre team and SFA, the nursing model for theatres can be reduced by 1 WTE band 3 overall, generating a saving.

It is anticipated that the role of RAS Coordinator will be allocated dependent on skill mix and theatre allocation.

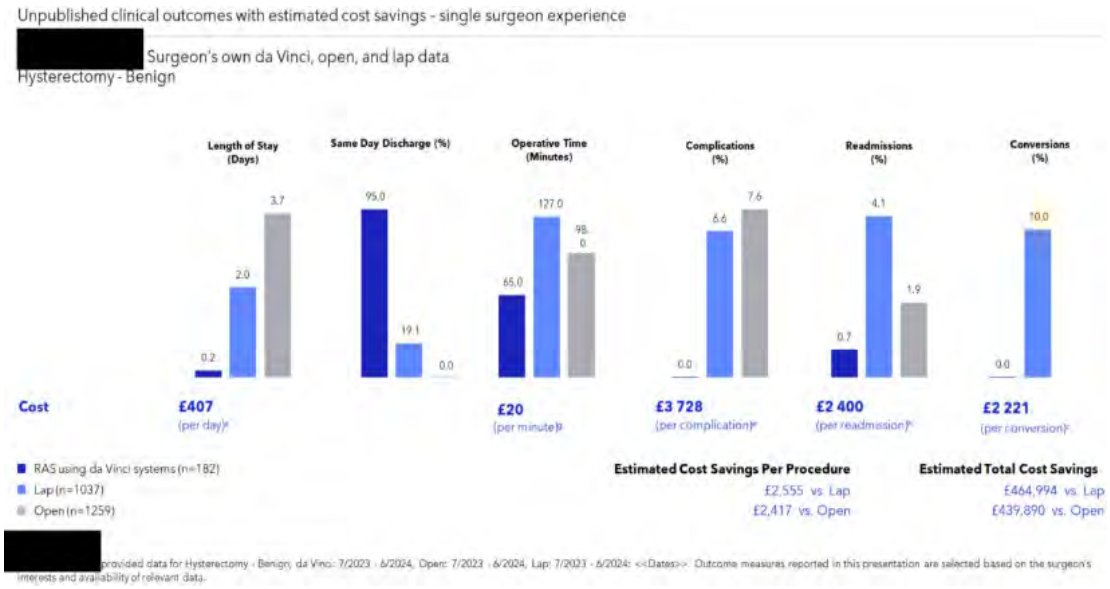
Trainees are exposed to RAS cases in other Boards, and this recognition of normal practice, has now been incorporated into their training programmes, with both the Royal College of Surgeons and the Royal College of Obstetrics & Gynaecology having launched robotic Advanced Training Study Modules (ATSMs) to address this.

2.4 Impact on Productivity and Waiting Times

There should be no detriment to surgical waiting times. Currently, the general surgeons perform one major case per list, depending on the complexity of cancer. If the case is less complex, then an additional small case or two would be added. It is not anticipated that this will change with RAS. Once expertise is gained, capacity may be doubled for major cases by performing two major cases on a RAS list.

In Gynaecology, there would be 1-2 majors per list for cancer plus minor cases. However, there is a Scottish Gynaecologist performing 5 benign RAS hysterectomies per day, with 95% as day case procedures, which would significantly help reduce gynaecology waiting times. This would be considered when moving into the next phase of increasing productivity beyond cancer care.

Picture 6. Example of RAS use in benign hysterectomy with estimated cost avoidance of £2500 per procedure



2.5 Decontamination Services for Robot Assisted Surgery

The NHS GG&C site at Cowlairs is validated to reprocess instruments for robotic assisted surgery and currently supports the robotic surgery procedures performed by other Boards. There is no local contingency support for robotic instrumentation within the West of Scotland. The private sector may have options in the future, but these costings have not been explored.

Assessments have been made to cost setting up the service in NHS Forth Valley versus sending the instruments elsewhere.

An external provider would have to guarantee increasing the capacity as the programme expands and have a rapid turnaround time. It is likely there would be a requirement to invest in additional instrumentation to mitigate risk.

Da Vinci Tray - £99.83
Da Vinci Supp - £66.55
Most cases use 2 trays

Implementation	Number of RAS cases	Processing costs
Year 1	200	£39,932
Year 2	350	£69,881
Year 3	400	£79,864

This does not include transport costs and other ancillary costs which would need to be worked through in an SLA.

2.6 Area Sterilisation and Decontamination Unit (ASDU) Adaptation

The introduction of RAS requires special provisions to be made within ASDU. Indicative costs have been provided by ASDU with capital cost requirements for in-house expansion, and recuring costs, versus external provider for recurring costs. (see Finance section 6).

Indicative capital costs are estimated at £138k. Additional resources are required and costed for an additional sink, washer racks, V Pro Steriliser and staggered staffing increases, in line with increasing case numbers (See Finance sections 6 and 7).

The FV ASDU will require some infrastructure works prior to being able to process the RAS instruments, so initially the instruments would require to be outsourced until the local works were completed.

There is also a need to increase staff by 1 WTE band 3 and 0.8 WTE band 4 initially to support the altered process of cleaning, but this workload would be kept under review.

2.7 Theatres

Theatre 3 has been identified as the dedicated RAS theatre, with theatre 4 available during theatre maintenance periods.

Medical physics have confirmed that there will be no additional infrastructure costs to connect a robot in theatre. LAN cables are available, and the floor can hold the weight capacity in both proposed theatres.

There is a maintenance contract with Intuitive, but medical physics have also requested 0.2WTE, 7.4 hours per week hours per week of a band 6 to support this, based on their experience with supporting this technology in NHS Lanarkshire.

The National Procurement process has also supplied free access to the Intuitive Hub for storage, learning and teaching facilities for other Health Boards.

The IT & Digital department has been engaged to assess any costs associated with storage within the server, and costings are awaited. They have also indicated there would be no capacity to support any installation need until Spring 2026. However, other assessment work could be undertaken remotely before this time. There are 2 phases of IT. The first phase allows firewall access to provide information on how many cases are performed and the length of time the robot is docked with each one. Phase 2 allows the system to capture videos of procedures for teaching and training.

2.8 Financial Context

There was a significant Scottish Government expansion of robotic systems in 2021. Whilst they originally intended to fund a Phase 2 roll-out of RAS, there has not yet been confirmation of the expected timescales. NHS Forth Valley were initially advised to continue with a business case, which if supported by local governance, and in principle by the regional RAS Group, would be considered if monies become available in future. Since then the NHS Forth Valley has received confirmation from the National Infrastructure Board, of capital funding up to £2.5m for the purchase of a robot.

National Procurement has assisted with the purchases, and the National Infrastructure Board has covered the costs of capital purchase for other Health Boards to date, providing the Da Vinci Xi dual console RAS system, Intuitive Hub, Theatre table, 6 scopes, along with associated infrastructure capital costs arising due to RAS implementation.

Revenue costs on an ongoing recurring basis require to be met from NHS Board resources.

2.9 Governance

Once the capital purchase has been agreed, a weekly implementation group would be set up to ensure the processes are in place to oversee each stage. There would be 5 subgroups; Operational Implementation, Decontamination and Procurement, Patient Pathways, Workforce and Education, Data and Information.

Upon delivery of the RAS system, it would be utilised immediately for simulation training for the selected surgeons. However, IT/Digital have advised further input is required prior to full installation.

There is a robust training programme for all staff, with sign off at each stage before progression. An invite has already been sent to surgeons, anaesthetists and theatre staff and clearly states the commitment required. It also advises that if progression and outcomes are not meeting the expected standards, they would be asked to give the opportunity to another colleague.

There has been an enthusiastic response received from our local staff groups. The 3 colorectal surgeons, 2 gynae surgeons and 1 urologist will be the initial consultants to train. There are several anaesthetic colleagues who already have experience in RAS, and the theatre teams have also expressed their commitment to becoming part of a dedicated, multi- specialty robotic team.

It is proposed that a Robotic Surgery Governance Group is established. Agreed measurable outcome data will be collected, and any adverse events highlighted through the IR1 system. Once established, the committee will meet on a quarterly basis and comprise representatives from the Surgical Directorates undertaking robotic surgery, theatres, audit and governance lead, plus Intuitive representatives. Any learning will be

widely shared.

The Robotic Surgery Governance group will report directly to the Medical Director, NHS Forth Valley.

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The Robotic Surgery Governance group will report directly to the Medical Director, NHS Forth Valley.

3. Identify Benefit Criteria

This section looks to identify the benefits that will be realised by meeting the objectives set for investment. The benefits are ranked to support future evaluation. From the organisational objectives and patient benefits, it was possible to develop a list of

benefits criteria. These are included in the table below.

Table 7. Benefits

Criteria	Description
Planning for the Future/ Strategic context	• How consistent is the option with NHSFV's strategic priorities? • To what extent will the option increase capacity in line with demand?
Safety of Service Provision	• To what extent is the option likely to improve patient safety?
Clinical Outcomes	• To what extent will the option improve clinical outcomes within the population/ cohort?
Quality of Service Provision	• How well will the option improve the patient's experience of the care they receive? • To what extent will the option improve patients' access to more modern approach to care?
Best Value using our resources	• To what extent does the option take advantage of the latest innovations to provide more efficient and more effective services? • To what extent is the option likely to improve the efficiency of services? • To what extent will the phasing of the development allow the highest priority patients to access services first? • To what extent will the option likely strengthen staff recruitment and retention?

3.1 National Evidence

RAS has been expanding rapidly across Scotland, and the benefits being delivered by RAS across Scotland have been collated by the national RAS Oversight Group.

In 2021, there were 1564 RAS procedures completed in Scotland. It was estimated that 5056 occupied bed days were saved and the cost avoidance related to reduced length of stay, complications and readmissions was £3.3M.

Nationally, it is expected that the benefits and efficiencies from RAS will continue to increase from the 2021 position. If RAS progresses to replace conventional procedures in 50% of suitable cases (a conservative estimate), the cost avoidance opportunity in Scotland is estimated to be £16M including 12,818 general bed days and 3208 critical care bed days saved.

The above represents estimated impact, however there is now actual data being presented on the real RAS deliverables, with reporting of 2021/22 colorectal data from Glasgow Royal Infirmary. This clearly demonstrated the delivery of clinical and efficiency benefits including:

- Reduction in LoS from 12 days to 5 days
- Reduction in blood transfusion from 24% to 2%
- Reduction in requirement for post-op CT scan from 41% to 16%
- Reduction in return to theatre from 9% to 5%

NICE announced in April 25 that they have now approved 5 systems for soft tissue surgery and will be collecting outcome data over the next 3 years to fully assess the cost benefits.

Below we demonstrate the compelling arguments for adopting an RAS platform within NHS Forth Valley:

1. Equity of access to RAS systems for patients of NHS Forth Valley.
2. Reduction in hospital length of stay
3. Reduction in immediate post-operative complications, including less anastomotic failure.
4. Reduced risk of blood loss. Reduced wound infection rates.
5. Reduction in return to theatre and re-admission – Large case series from centres of robotic excellence in England illustrates the potential for not defunctioning patients requiring anterior resections for low rectal cancer (avoids a stoma bag). RAS allows suturing in the low pelvis. Intracorporeal anastomosis for right hemicolectomy using RAS reduces midline extraction points, enabling surgeons to remove the specimen entirely from Pfannenstiel extraction site (low transverse incision rather than midline). This reduces the number of incisional hernias following midline incision and reduces delayed operative complications.
6. Reduced utilisation of critical care beds – with an improved rate of MIS and reduced conversion from RAS surgery to open surgery, there will be a reduction in need for critical care beds.
7. Better theatre utilisation and potential reduction of operative time.
8. Improvement in functional outcomes – A frequent and under reported complication of rectal cancer surgery, is a compromise in function. This may be related to loss of bowel and bladder control and sexual dysfunction. It is reported in the literature that these adverse outcomes can complicate anywhere up to 50% of cases, although patients tend not to admit these complications due to the emotive nature of these issues. RAS offers the ability for precise dissection and preservation of the branches of the hypogastric nerve plexus, thus preserving function and preserving the patients' quality of life.
9. Occupational risk reduction – There is evidence to suggest a reduction in repetitive strain injury, as well as back and neck injuries, associated with laparoscopic surgery in surgeons adopting robotic surgery due to the ergonomic design of the platform.

3.3 Beneficial Economic Outcomes:

1. Workforce recruitment and retention – both medical and nursing staff in all affiliated directories including surgery, gynaecology, urology and anaesthetics are reliant on a vibrant and innovative hospital environment, providing fertile ground for new ideas and strategies to improve patient centred care and outcomes. Trainees are exposed to RAS surgery which has been incorporated into their training programme. To remain competitive as a Health Board in providing the very best treatment for our patients, new technologies must be used. Investment in innovation and quality improvement will attract high quality health professionals, with ambitions to push boundaries and improve outcomes.

2. Reduced length of hospital stay – as demonstrated in many clinical settings and most recently at the GRI, NW and A&A data, length of stay is reduced after RAS systems are utilised. This translates into significant cost avoidance. Predictions for NHS Forth Valley suggest that we could save up to 695 bed days annually.

3. Better patient experience – Patients are often extremely knowledgeable about their care and health conditions, and some have requested their surgery is performed using the robot. They are anxious that NHS Forth Valley isn't using the very best and most up to date equipment, when compared to other neighbouring Health Boards, which results in challenging conversations with our surgeons. The team feels that the excellent care delivered locally would be enhanced significantly by being able to offer RAS.

4. Generate Options

There are 4 options for Forth Valley:

Option A: Status quo/Do nothing – Current model in NHS Forth Valley: No

access for Colorectal patients to receive Robotic Assisted Surgery.

Continue to refer some Urology and Gynaecology patients for RAS surgery within GG&C. Local patients have access to Laparoscopic or open surgery only.

Option B: Create more capacity in the West of Scotland - Patients travel:

Potential to expand access to robotic colorectal surgery. Patients have their care elsewhere, paid for by NHS FV.

Option C: Create more capacity in the West of Scotland – Patients and Surgeons travel:

Potential to expand access to robotic colorectal surgery, with surgery performed by FV surgeons. Our surgeons travel with patients to operate at another site. Costs of surgeon travel time etc. in job plans equates to 3 additional PAs per surgeon for travel time, overnight stay and day 1 post-op ward round. Also need accommodation for surgeons plus the cost of patient treatment, paid for by NHS FV.

Option D: Procure robotic assisted surgery (RAS) in Forth Valley:

Forth Valley patients have access to robotic assisted surgery at FVRH. This would start with cancer surgery for colorectal cases initially and develop to include gynaecology and urology cancers. This is in line with the approach across Scotland to offer RAS for all appropriate cancer and complex benign cases.

A SWOT analysis was conducted for each of the options on the long list, and this is summarised in the tables below.

Option A: Status quo/Do nothing	
Strengths	• No investment for robotic assisted surgery required.
Weaknesses	• Unmet demand and unequal access, with FV patients missing out on access to robot assisted colorectal surgery, compared to other Boards in the region. • Inequalities in care through lack of access to surgical technologies with evidenced improvement in outcomes. • Inability to deliver clinical and economic benefits. • Patient experience – travelling out of area. • Newer and more advanced laparoscopic equipment would need to be sought if we do not procure a robot.
Opportunities	• None identified.
Threats	• Forth Valley is at a disadvantage to Health Boards. • Difficulty in recruitment and retention of high-quality clinical staff and surgical trainees. • Organisation is open to complaints. • Costs of RAS procedures elsewhere may increase

Option B: Create more capacity in the West of Scotland - Patients travel	
Strengths	• Potentially reduce waiting times/access to service. • Patients benefit from RAS.
Weaknesses	• Inability to deliver clinical and economic benefits – increased cost to NHS FV • Newer and more advanced laparoscopic equipment would need to be sought if we do not procure a robot. • Patient experience – travelling out of area. • Potentially no additional capacity in WoS for Forth Valley patients may increase waiting times and reduce 62 day performance
Opportunities	• None identified.
Threats	• Difficulty in recruitment and retention of high-quality clinical staff and surgical trainees. • No opportunity to expand the use of robotic surgery holding Forth Valley back.

Option C: Create more capacity in the West of Scotland – Patients and Surgeon travel.	
Strengths	• Potentially reduce waiting times/access to service.
Weaknesses	• Inability to deliver clinical and economic benefits higher cost • Newer and more advanced laparoscopic equipment would need to be sought if we do not procure a robot. • Patient experience – travelling out of area. • Sustainability – greener Scotland campaign, increased travel • Potentially no additional capacity in WoS for Forth Valley patients. • Surgeon's additional time– cost to the service. • Inefficiencies in flexibility for surgical team. • Lack of peer support.
Opportunities	• Surgeons have access to RAS training
Threats	• Difficulty in recruitment and retention of high-quality clinical staff and surgical trainees when no inhouse RAS opportunities • No opportunity to expand the use of robotic surgery in NHS FV.

Option D: Procure robotic assisted surgery (RAS) in NHS Forth Valley	
Strengths	• Improve long term patient outcomes, minimal blood loss, less post-operative pain and quicker return to normal activities. • Reduce return to theatre and complications. • Reduce length of stay. • Increase potential planned care bed capacity • The service will be sustainable and cost-effective in the long term. • Better ergonomics for surgeons with reduced injury • Better patient experience. • Sustainability – greener Scotland, less travel
Weaknesses	• Investment required.
Opportunities	• Will continue to support NHS Forth Valley in attracting and retaining high quality clinical staff and surgical trainees. • Multi-specialty robot providing access for General surgery, gynaecology and urology patients . • Minimising the risk of complaints to the board.
Threats	• None identified.

5. Scoring of Options against Benefit Criteria

5.1 Weighting Criteria

The weighting criteria totals 100 and the greater the perceived importance, the higher the weight assigned. The Option Appraisal exercise approved the weightings by consensus.

Table 8: Weighting of criteria

	Benefit Criteria	Weight
1	Planning for the Future/ Strategic context	10
2	Safety of Service Provision	25
3	Clinical Outcomes	25
4	Quality of Service Provision	25
5	Best Value using our resources	15

5.2 Scoring of Options

In January 2024, Samantha Morrison (Project Manager, Department of Public Health NHS Forth Valley) collated and agreed scoring for each of the options against the criteria. This was multiplied by the weighting for each criterion, and totaled, to give a final score for each option.

KEY

C = Criteria
W = Weighting (total weight of criteria is 100)
S = Score from 1 to 5, 5 being fully meets criteria and 1 being fails to meet criteria
S x W = score times weight to give weighted score for each option against each criteria, added together to give the total weighted score (maximum 500)

Table 9. Scoring

Options		A		B		C		D	
C	W	S	SxW	S	SxW	S	SxW	S	SxW
1	10	1	10	2	20	1	10	5	50
2	25	3	75	1	25	2	50	5	125
3	25	2	50	2	50	2	50	5	125
4	25	2	50	1	25	2	50	5	125
5	15	1	15	1	15	2	30	5	75
TOTAL	100		200		135		190		500

The scoring suggested that Option D offered the most patient benefit and value for money and this is therefore the preferred option. **OPTION D = Procure robotic assisted surgery (RAS) in NHS Forth Valley**

6. Economic appraisal

The Net Present Cost (NPC) for each option was calculated to evaluate total net cash outflows over the robot's recommended 7-year lifespan, with all future net cash outflows discounted to their present value. This allows for direct comparison of NPCs across options. Generally, when making investment choices, the option with the lowest NPC is considered the most favorable.

Note that a discount factor of 3.5% was applied in line with Scottish Capital Investment Manual guidance. This is defined as a real terms rate and must therefore be applied to values which are also expressed in real terms. As a result, the anticipated effects of inflation were removed from the figures before discounting.

Table 10 below summarises the NPC of each option (further detail is provided in appendix 3). The option with the lowest NPC is option D3 - outright purchase of the robot.

Table 10: Summary of Net Present Cost per option	£m	Rank
B - Forth Valley patients referred to another board	£22.51m	**4**
C - Forth Valley employed surgeon operating in another board	£23.95m	**5**
D1 - Lease of robot	£6.27m	**2**
D2 - "Pay as you go" robot	£7.03m	**3**
D3 - Purchase of robot	£6.18m	**1**

7. Financial appraisal

The capital and revenue cost implications of each option were assessed over the 7-year lifespan of the robot to determine the impact on the NHS Board's Accounts. Note that optimism bias of 10% is included across all cost categories in line with Treasury green book guidance for capital investment in equipment.

Capital costs vary with each option as summarised below:

- Options B and C do not incur any capital costs.

- Option D1 involves leasing the robot. This would be classed as a "right of use" asset under International Financial Reporting Standard 16 (IFRS 16) and therefore must be recognised on the Board's balance sheet. As such, this will require capital

funding equivalent to the Net Present Value[1] of the total lease payments (£2.1m). In addition, further capital costs of £0.3m are also expected to be incurred to support the necessary ASDU upgrades and purchase of other associated theatre equipment.

- Option D2 is structured as a "pay as you go" arrangement. The associated capital costs are estimated at £0.3m, which relate solely to the required ASDU upgrades and associated theatre equipment. However, when applying the accounting principle of substance over form[2] to this option, it is probable that External Audit would classify this as a lease arrangement, similar to option D1. As such there may be additional material capital cost implications associated with this option pending audit opinion. For illustrative purposes, the cost estimates assume that this is not deemed to be a lease.

- Option D3 refers to the outright purchase of a robotic system. Under this option. the capital cost is equivalent to the estimated purchase price (£2.3m). Additional capital costs are also expected to be incurred (£0.3m) in relation to the necessary ASDU upgrades and associated theatre equipment.

Revenue costs vary with each option as summarised below:

- Option B – non-recurring revenue costs of £0.09m are anticipated as a contribution towards the cost of additional instrumentation (this is likely to be requested by the provider Board). The recurring revenue costs (£27.5m over the 7-year term) reflect estimated cross-boundary service charges based on direct costs only (no allowance is made for overhead recharges). This is offset by savings on staff costs as fewer General Surgeons would be required locally under this option (saving is estimated at £3.4m over the 7-year term). Service Level Agreement (SLA) inflation is estimated at 3.5% for 26/27 and 2% pa thereafter.

- Option C - non-recurring revenue costs of £0.09m are anticipated as a contribution towards the cost of additional instrumentation (this is likely to be requested by the provider Board). The recurring revenue costs (£29.2m over the 7-year term) reflect estimated cross-boundary service charges (direct costs only) plus local Consultant oncall arrangements (which are costed at the top of the 25/26 Consultant pay scale with a 3% pa uplift applied thereafter). Service Level Agreement (SLA) inflation is estimated at 3.5% for 26/27 and 2% pa thereafter.

[1] A discount rate of 5.32% has been used in the Net Present Value calculation as per Public Expenditure System paper 2025 09 published by the Treasury.

[2] The substance over form principle directs accountants to record transactions according to their genuine economic reality, rather than merely their legal appearance. This ensures that financial statements present an accurate and honest picture of an organisation's financial position. The economic substance of the Pay As You Go arrangement is likely to be viewed as being similar to a lease by External Audit. In which case the capital and revenue costs would largely mirror option D1.

- Option D1 - non-recurring revenue costs of £0.3m are estimated in relation to new instrumentation and training costs (offset by a £0.1m credit from the manufacturer towards initial instrumentation). The recurring revenue costs (£6.8m over the 7-year term) reflect additional staffing[3] requirements in ASDU (1.36 WTE) and Medical Physics (0.2 WTE) together with maintenance contracts, consumables (including increased instrumentation), software costs, capital charges and finance lease interest. This is offset by projected savings on laparoscopic instruments and theatre staff (1 WTE). General price inflation of 2% pa is included.

- Option D2 - non-recurring revenue costs of £0.4m are estimated in relation to new instrumentation and training costs. The recurring revenue costs (£7.7m over the 7-year term) reflect additional staffing requirements in ASDU (1.36 WTE) and Medical Physics (0.2 WTE) together with "pay as you go" charges, maintenance costs, consumables (including increased instrumentation) and software fees. This is offset by projected savings on laparoscopic instruments and theatre staff (1 WTE). General price inflation of 2% pa is included.

- Option D3 - non-recurring revenue costs of £0.3m are estimated in relation to new instrumentation and training costs (offset by a £0.1m credit from the manufacturer towards initial instrumentation). The recurring revenue costs (£6.3m over the 7-year term) reflect additional staffing requirements in ASDU (1.36 WTE) and Medical Physics (0.2 WTE) together with maintenance contracts, consumables (including increased instrumentation), software costs and capital charges. This is offset by projected savings on laparoscopic instruments and theatre staff (1 WTE). General price inflation of 2% pa is included.

Table 11 below summarises the total capital and revenue costs of each option (further detail is included in appendix 3).

Table 11: Summary of costs over 7 year lifespan of the asset	**Option B £m**	**Option C £m**	**Option D1 £m**	**Option D2 £m***	**Option D3 £m**
Capital costs	£0.00m	£0.00m	£2.46m	£0.33m	£2.59m
Net revenue costs - non-recurring	£0.09m	£0.09m	£0.28m	£0.42m	£0.28m
Net Revenue costs - recurring	£27.53m	£29.16m	£6.75m	£7.66m	£6.30m

* Assumes that this option is NOT deemed to constitute a lease. If audit consider the substance of this option to be a lease then the capital & revenue costs would be similar to option Di.

Average cost per procedure	**Option B**	**Option C**	**Option D1**	**Option D2**	**Option D3**
	£10,794	£11,436	£2,647	£3,003	£2,470

Option D3 – outright purchase of the asset demonstrates the lowest recurring revenue cost and the lowest average cost per procedure.

[3] Staff costs in all options are based on the top of the relevant 25/26 payscale including employer's oncosts (with pay awards of 3.75% in 26/27 and 3% thereafter for AfC staff. 3% in all years for Medical staff).

8. Affordability and Value for Money

The capital and revenue costs of the preferred option (ie option D3) have been compared to available funding sources to determine overall affordability.

Capital funding of £2.6m is required to fund the outright purchase of the robot and carry out the necessary local decontamination upgrades. £2.5m of this will be funded by the Scottish Government via the NiB, with the balance of £0.1m coming from the Board's formula capital allocation.

In terms of the revenue consequences, a net additional recuring funding requirement of c£0.6m pa is projected (£4.0m over the 7-year term) as summarised in table 12 below.

Table 12 : Option D3 revenue affordability assessment	**Year 0 £m**	**Year 1 £m**	**Year 2 £m**	**Year 3 £m**	**Year 4 £m**	**Year 5 £m**	**Year 6 £m**	**Year 7 £m**	**TOTAL £m**
Revenue costs (non-recurring)									
Initial Instrumentation & Trays	£0.08m								**£0.08m**
Staff training		£0.17m							**£0.17m**
Additional decontamination		£0.03m							**£0.03m**
Sub total non-recurring	*£0.08m*	*£0.20m*	*£0.00m*	*£0.00m*	*£0.00m*	*£0.00m*	*£0.00m*	*£0.00m*	***£0.28m***
Revenue costs (recurring)									
Pay costs		£0.08m	£0.11m	£0.11m	£0.11m	£0.12m	£0.12m	£0.12m	**£0.78m**
Maintenance charges & fees		£0.02m	£0.22m	£0.23m	£0.23m	£0.24m	£0.24m	£0.25m	**£1.42m**
Software		£0.00m	£0.02m	£0.02m	£0.02m	£0.02m	£0.02m	£0.02m	**£0.11m**
Capital charges/depreciation		£0.32m	£0.32m	£0.32m	£0.32m	£0.32m	£0.32m	£0.32m	**£2.27m**
Consumables (incl extra instrumentation)		£0.45m	£0.86m	£0.98m	£1.00m	£1.02m	£1.04m	£1.06m	**£6.41m**
Saving (theatre staff & laparoscopic instruments)		-£0.33m	-£0.59m	-£0.72m	-£0.74m	-£0.75m	-£0.77m	-£0.79m	**-£4.69m**
Sub total recurring	*£0.00m*	*£0.54m*	*£0.94m*	*£0.94m*	*£0.95m*	*£0.96m*	*£0.98m*	*£0.99m*	***£6.30m***
Funding sources									
Minor works (non-recurring)	£0.08m								**£0.08m**
ADEL (non-recurring)		£0.20m							**£0.20m**
AME/non-core RRL		£0.32m	£0.32m	£0.32m	£0.32m	£0.32m	£0.32m	£0.32m	**£2.27m**
Total available funding	£0.08m	£0.53m	£0.32m	£0.32m	£0.32m	£0.32m	£0.32m	£0.32m	**£2.55m**
Recurring shortfall	**£0.00m**	**(£0.22m)**	**(£0.62m)**	**(£0.61m)**	**(£0.63m)**	**(£0.64m)**	**(£0.65m)**	**(£0.67m)**	**(£4.03m)**

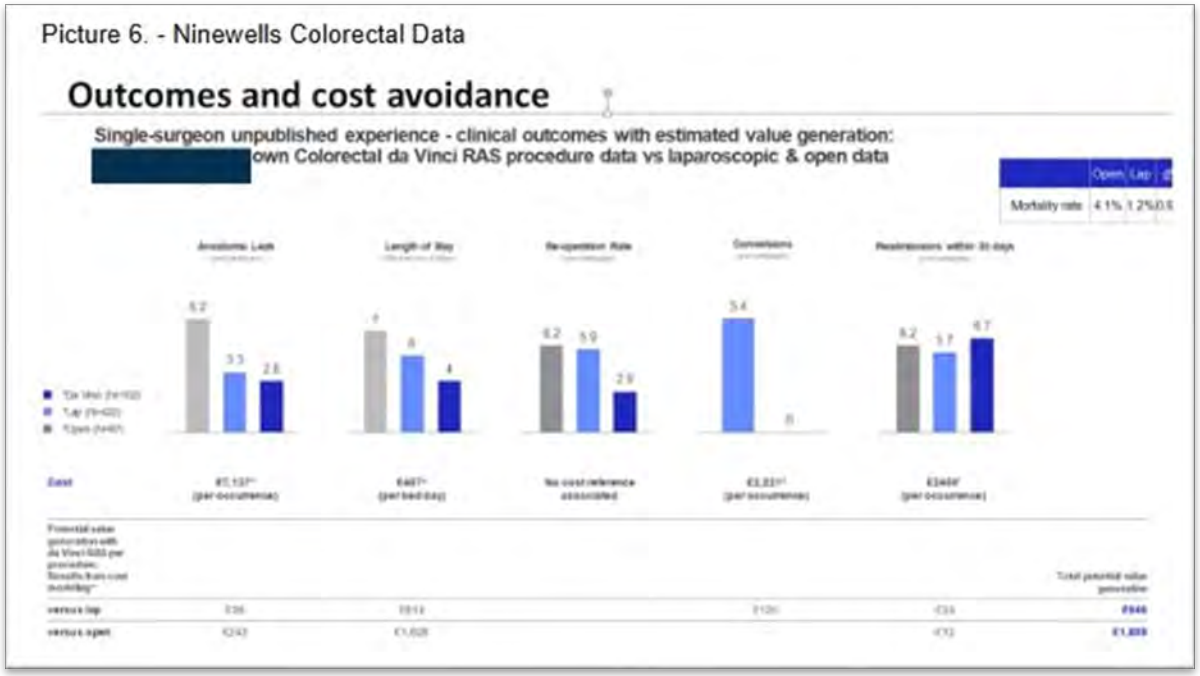
Year 1 costs will be met by an additional funding allocation which has been confirmed by Scottish Government. Future year revenue costs from 2027/28 have been included in the NHS Board Financial Plan.

A recurring funding source will be identified before 31st March 2027, based on evidence of actual costs incurred in the first year of operation, focusing on cash releasing service efficiencies and prioritising contribution from wider cost savings initiatives where required.

It is recognised that other productivity and cost avoidance savings are expected to be generated by the robot in the longer term. The pictures below show the improved patient outcomes, and the cost avoidance associated with each.

The first is Ninewells colorectal cancer data. This shows that using RAS demonstrates a cost difference of £946/ case less with RAS than laparoscopic and £1859/ case less versus an open case in colorectal patients.

Picture 6. - Ninewells Colorectal Data


Outcomes and cost avoidance
Single-surgeon unpublished experience - clinical outcomes with estimated value generation:
[redacted] own Colorectal da Vinci RAS procedure data vs laparoscopic & open data
Mortality rate
Cost

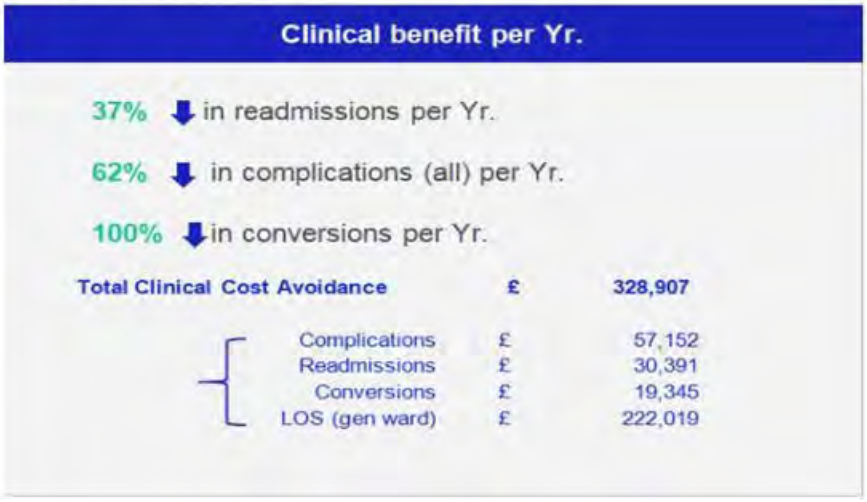
The second picture demonstrates savings in Ninewells using RAS for endometrial cancer cases.

Picture 7. Gynaecology Data

Again, comparing Gynaecology hysterectomies, there is a cost avoidance of £450 per case versus laparoscopic.

The data below shows the actual cost avoidance per year based on 344 combined, colorectal, gynaecology and urology cases in Ninewells in financial year 23/24.

Picture 8 – Cost avoidance Ninewells


Clinical benefit per Yr.
37% in readmissions per Yr.
62% in complications (all) per Yr.
100% in conversions per Yr.
Total Clinical Cost Avoidance £ 328,907
Complications £ 57,152
Readmissions £ 30,391
Conversions £ 19,345
LOS (gen ward) £ 222,019

RAS results in less complications and a shorter length of stay. This reduces demand on critical care, blood transfusion and theatre teams.

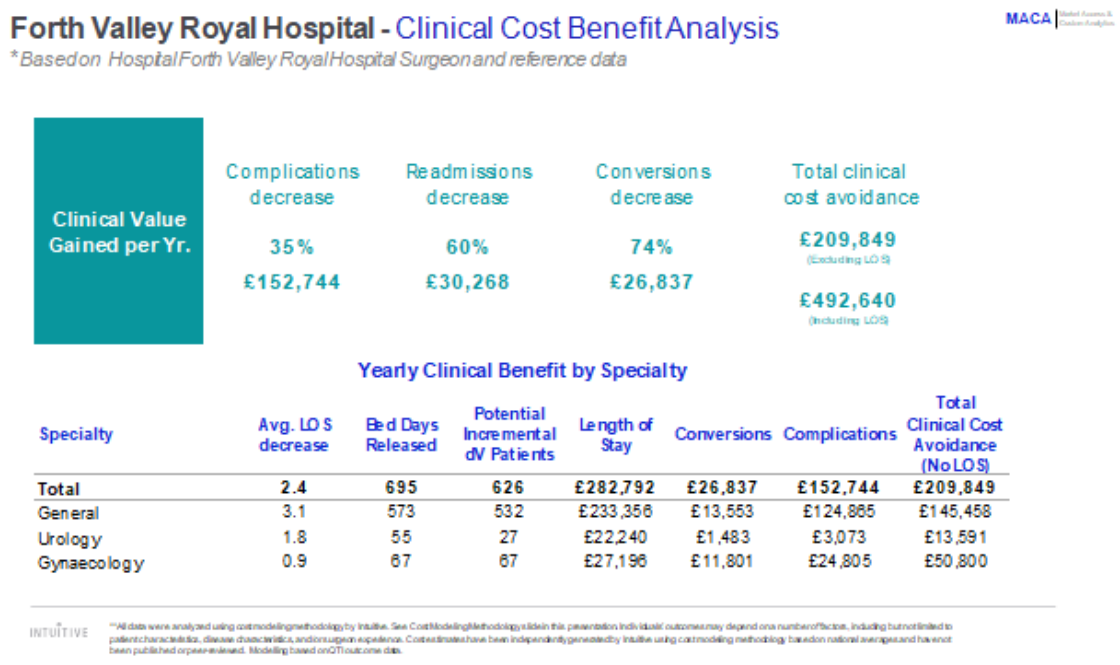
Picture 9. Productivity

Operational & productivity benefit per Yr.
Average LOS 1.6 days
Bed days released annually 546
Potentially treat an additional 241 patients per Yr.
70% in potential patients treated annually
41% in total bed days used

The shorter length of stay, frees up bed capacity for other elective care patients. This could help local waiting times or be used to provide mutual aid. This must be balanced against the cost of using more consumables, with increased operative cases.

The predicted cost avoidance for NHS Forth Valley, using our own data is shown in the slide below. This shows the site could release 695 bed days annually and achieve an associated cost avoidance of £492,640 per year.

Picture 10. NHS FV Value for Money Prediction



Forth Valley Royal Hospital - Clinical Cost Benefit Analysis

MACA

*Based on Hospital Forth Valley Royal Hospital Surgeon and reference data

Clinical Value Gained per Yr.	Complications decrease	Readmissions decrease	Conversions decrease	Total clinical cost avoidance
	35%	60%	74%	£209,849 (Excluding LOS)
	£152,744	£30,268	£26,837	£492,640 (Including LOS)

Yearly Clinical Benefit by Specialty

Specialty	Avg. LOS decrease	Bed Days Released	Potential Incremental dV Patients	Length of Stay	Conversions	Complications	Total Clinical Cost Avoidance (No LOS)
Total	**2.4**	**695**	**626**	**£282,792**	**£26,837**	**£152,744**	**£209,849**
General	3.1	573	532	£233,356	£13,553	£124,865	£145,458
Urology	1.8	55	27	£22,240	£1,483	£3,073	£13,591
Gynaecology	0.9	67	67	£27,196	£11,801	£24,805	£50,800

INTUITIVE

**All data were analyzed using cost modeling methodology by Intuitive. See Cost Modeling Methodology slide in this presentation. Individuals' outcomes may depend on a number of factors, including but not limited to patient characteristics, disease characteristics, and/or surgeon experience. Cost estimates have been independently generated by Intuitive using cost modeling methodology based on national averages and have not been published or peer-reviewed. Modelling based on OTI out.one data.

9. Risk

Potential risks and Impacts to Forth Valley

- Securing a robot now will re-enthuse the surgical teams, make Forth Valley a more desirable employer, and keep our cancer services sustainable. Lack of robotic development will have a negative impact on the whole team.

- New recruitment may be challenging without a robot and may influence retention of the existing team.

- Forth Valley is an excellent training centre for the WOS trainees with outstanding feedback from the national training survey[10]. Lack of a robotic platform will compromise the training for trainees, where there is an expectation that robotics will become a more wide-spread modality of future service delivery.

- Limiting robotic surgery to tertiary centres leads to central migration of these skills with movement of the trainees and surgeons to those centres, causing immense pressure to the delivery of emergency care in DGH's.

- DGHs need to remain attractive and viable as capacity (theatre, critical care, bed capacity) within teaching hospitals is limited.

- Although funding has been confirmed to meet revenue costs for the first year of operation, further cash releasing savings require to be identified and delivered from April 2027 to offset ongoing running costs. This will require to be addressed as a priority during 2026/27 as part of the NHS Board's savings programme.

10. The Preferred Option

The preferred option is:

Option D: Procure Robotic Assisted Surgery (RAS) in Forth Valley: Forth Valley patients have equal access to multi–specialty robotic assisted surgery for cancer surgery. The service would accommodate future appropriate expansion of RAS for complex benign cases to ensure full utilisation of the robotic system.

11. Benefits Realisation Plan

The benefits are outlined in Table 11 below along with the measurement criteria. This shows how performance will be reviewed and will include baseline measures from which improvements will be calculated.

Benefit description	Benefit measurement criteria
Equity of access to RAS systems for surgery	Collect numbers of patients undergoing RAS procedure in General surgery, Gynaecology and Urology annually to demonstrate improved access
Reduction in hospital Length of stay (LOS)	Collect LOS data for all RAS procedures and compare to LOS for same laparoscopic cases to demonstrate reduction.
Reduction in immediate post-operative complications	All significant post-op complications should be reported via IR1s. e.g. anastomotic leak, conversion to open etc. RAS surgeons expected to audit outcomes and present at local governance meetings to identify and review all complications and compare against previous laparoscopic outcomes.
Reduced risk of blood loss and wound infection rates	Numbers of patients requiring blood transfusion after RAS will be collected as an outcome measure and compared to previous figures. This should evidence a reduction in blood loss. Surgical sites infection data to be collected for all RAS cases and compared with laparoscopic figures.
Reduction in return to theatre and readmission	Unplanned return to theatre within 30 days should be reported via IR1 system. The numbers of cases who require a second operation will be reviewed annually as a comparison but would be expected to be reported 3 monthly by the surgeon through the RAS governance process. Unplanned readmission within 30 days should also generate and IR1 and review. Again these set criteria would be collected by the surgeons to present their data quarterly, allowing early review of the reasons.
Reduced utilisation of critical care beds	Many complex elective cases have planned admission to critical care. The numbers of elective and unplanned post-op RAS admissions and their LOS in critical care will be collected for comparison.
Better theatre utilisation and potential reduction in theatre time	The RAS system automatically collects data on the duration of the surgery, and numbers of cases per list. Intuitive produce quarterly reports for the surgeon and hospital site, with no patient identifying data, to allow a review of procedure length and this usually reduces as experience increases. The OPERA theatre system allows collection of theatre data to assess utilisation and fallow time. We can also assess numbers of cases per list to see if this increased as duration of surgery reduces.
Improvement in functional outcomes and batter patient experience	Patients will be asked to complete quality of life questionnaires at set post-op stage to assess recovery. These will be collated by the surgeon.
Recruitment and retention of staff	Exit interviews should be offered for any leaving staff members to understand their reasons for leaving. Robotic access could be asked as part of this process. Number of applicants for new posts may increase with access to a robotic system. Numbers can be checked via HR.

12. Sustainability Implications

Laparoscopic cases require higher levels of intra-abdominal pressures to access the pelvis, so use more carbon dioxide (CO2) per case to inflate the abdomen. RAS allows surgeons to operate with lower pressures as the robotic arms lift the abdominal wall, and for a shorter time, thus reducing the amount of CO2 used per case.

The preferred option would reduce the need for patients or surgeons to travel out with Forth Valley for surgery, thus reducing the carbon footprint.

The majority of staff training would be provided in-house therefore no travel would be required.

13. Equal Opportunities / Equality Impact Assessment

Due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision-making process.

Further to an evaluation it is noted that: (please tick relevant box)

☐ Paper is not relevant to Equality and Diversity
☒ Screening completed - no discrimination noted
☐ Full Equality Impact Assessment completed – report available on request

14. Conclusions and Recommendations

The business case recommends the procurement of a Da Vinci Xi dual console system to provide Robotic Assisted Surgery in NHS Forth Valley, as a multi-specialty system. This would ensure equity of access to robotic assisted surgery for colorectal, gynaecology and urology cancer and complex benign cases resulting in better outcomes.

The reduction in complications and shorter length of stay leads to significant cost avoidance and an increase in bed capacity, which can improve hospital flow thus helping our unscheduled care performance, further reduce waiting times or be used for income generation with mutual aid.

To remain competitive and attractive as a Health Board who strives to provide the very best treatment for our patients, investment in recognised technology leading to quality improvement, will attract high quality healthcare professionals, with ambitions to deliver safer patient outcomes.

References

1. Head and neck cancer; ENT; Cardiothoracic Surgery
2. MCN Data
3. Shaping the Future: NHS Forth Valley Healthcare Strategy 2016-2021
4. NHS Forth Valley currently provides a high standard of care for colorectal cancer and has good outcomes.
5. Effect of Robotic-assisted vs Conventional Laparoscopic Surgery on Risk of Conversion to Open Laparotomy Among Patients Undergoing Resection for Rectal Cancer; The ROLARR Randomised Clinical Trial. Jayne et al., JAMA 2017;318(16):1569-1580
6. NHS Forth Valley will be overseen by 'robotic surgery governance group'
7. MCN Data
8. Guillou PJ et al. Short-term endpoints of conventional vs. laparoscopic-assisted surgery in patients with colorectal cancer (MRC CLASICC trial): multicentre, randomised controlled trial. Lancet. 2005; 365: 1718-1726; Carbonell, A et al. Reducing Length of Stay Using a Robotic-assisted Approach for Retromuscular Ventral Hernia Repair, Annals of Surgery: February 2018 - Volume 267 - Issue 2 - p 210-217
9. In cases where patients have undergone multiple previous operation, emergency cases, Cardiovascularly unstable patients or patients with significant cardiovascular comorbidity
10. WOS trainee feedback

Appendix 1 – Robotic Training

Introduction of new robotic procedures

1. A Business case to be approved by the Board
2. Approval by the new Intervention committee (supported by independent advice on robotic surgery)
3. Clear plan of named surgeons training log and sign in as per agreed protocol.

Surgeon training / sign off and audit requirements

New technology is guaranteed to attract new adopters. It is essential therefore, that there are clear governance and sign off arrangements in place for the safe introduction of robotic surgery into a surgeon's scope of practice, such that patients are not subject to unnecessary risk.

The following governance and sign off requirements have been in accordance with NHS Forth Valley Governance standards and are thus subject to standard NHS Forth Valley disciplinary pathways. They apply to surgeons with previous training and experience of robotic-assisted surgery elsewhere, and to those with no prior robotic experience who wish to add robotic-assisted surgery to their scope of practice.

Common requirements for all new procedures and surgeons include mandatory prospective audit of outcomes and interval presentation to the robotic surgery governance group after a specified number of cases, before full accreditation is granted.

An outline of the standard NHS Forth Valley accreditation pathway for robotic surgery is shown below.

Application for structured training on the RAS System

As outlined surgeons wishing to incorporate robotic surgery into their scope of practice must first demonstrate completion of the following requirements

- Evidence of an approved, fully costed business case for a specific procedure(s), signed off by the Clinical Director
- A letter of support from the applying surgeon's Clinical Director

Once all the above requirements have been achieved, surgeons should submit the documentary evidence to the robotic surgery governance group to apply for structured training on the RAS System. This is primarily to ensure that training and resources are co-ordinated and utilised as efficiently as possible. Structured training will comprise the following mandatory elements:

a. Intuitive Surgical Online Training Program
b. Da Vinci Surgery European Training Course (Intuitive Surgical)
c. Virtual reality training using the da Vinci skills simulator (minimum of 30-40 hours AND dexterity/accuracy scores > 90% for all parameters)
d. Observation of robotic surgery performed by the Intuitive surgical approved proctor.

It is the responsibility of each surgeon/ department to fund training as required.
All surgeons will be required to provide documentary evidence of completion of elements a - d.

The only permitted exemptions are in the case of Fellowship-trained robotic surgeons, and also newly appointed consultants who were already independently performing robotic surgery at other boards, who shall not be required to complete elements a - d.

To be considered a **fellowship-trained robotic surgeon,** an applicant will need to demonstrate that they have successfully completed no less than 9 months training at an established robotic training centre. Required documentation will include the following:

- Details of specific robotic training fellowship undertaken, including information regarding the amount of time spent on the following elements: theoretical training, number of simulator sessions, dry-lab training, operations performed as an assistant, and console time undertaken.
- A completed robotic training logbook.
- A certificate of completion of robotic training, or alternatively a letter of support from a robotic training supervisor confirming satisfactory completion of specific robotic training.

Established robotic surgeons newly appointed to NHS Forth Valley and intending to continue offering robotic surgery will need to submit the following:

- A letter of support from the lead clinician at their previous employing board confirming their competence to perform robotic surgery. A copy of their most recent appraisal will also need to be submitted.
- A completed surgical logbook demonstrating surgical outcomes from the last
- 12 months of robotic surgical procedures.
- Credentialing requirements for robotic surgical practice as outlined below.

Proctored surgical training and provisional accreditation

Documentary evidence confirming completion of the structured da Vinci surgical system training should be submitted along with the name and credentials of an applicant's chosen surgical proctor to the next robotic surgery governance group meeting.

Following a satisfactory review of training evidence and proctoring arrangements, surgeons will be granted provisional accreditation to commence proctored surgical training.

It will remain the responsibility of the clinical director to ensure the surgeon is getting trained as per agreed programme and any deviations or complications will be brought to the notice of RSGG.

Robotic Proctors/ Preceptors

Regarding surgical proctors, every attempt should be made to utilise existing robotic-trained surgeons already employed within a department, as this is not only the most cost-effective solution for the board, but also provides more robust governance measures.

Where this is not possible, for example where there are no robotically trained surgeons within a specific department, mandatory NHS Forth Valley requirements for robotic proctors are as follows:

- Surgeon already credentialed to perform robotic surgery elsewhere and has performed more than 100 robotic procedures.
- Has undertaken Training the trainer programme
- Surgeon on Intuitive Surgical Inc. and Royal College of Surgeons list of approved da Vinci Surgical System surgical proctors.
- Once appointed, ideally the same surgeon should attend all proctored cases for the mentee to ensure appropriate safety and progression. The use of multiple proctors is not desirable but can be sanctioned in exceptional circumstances.
- A proctor is required to be a surgeon of the same specialty as the training surgeon, and to be familiar with both the robotic and non-robotic form of the surgery. Ideally, they should be on hand to assist with specific issues pertaining to positioning, system docking and instrumentation, and system trouble-shooting.

However, it is expected that from time to time the proctor may be required to perform components of the surgery, for example to assist in difficult dissection, and ensure that the surgery is completed in a timely fashion.

- All visiting surgical proctors require Letter of Authority from Human Resources indicating that the proctor is indemnified by the board to supervise robotic training.
- Every effort should be made to avoid occurrence of adverse events. As such, all training surgeons will be required to undertake a minimum of 8 proctored surgical cases before being considered for independent surgical practice. Exceptions include Fellowship-trained robotic.

- Surgeons ideally are required to undertake a minimum of 5 proctored cases. Established robotic surgeons from elsewhere recently employed by NHS Forth Valley will still require observation by an internal proctor, for a minimum of 4 cases. Each proctored case should be signed off by surgeon, proctor, and scrub nurse or anaesthetist for submission to the robotic surgery monitoring group. Forms for this purpose are shown in the Appendix 2.

Independent practice and full accreditation

Surgeons will be granted permission to independently practice robotic surgery after completing the minimum required number of proctored cases as outlined above, and after submitting completed proctoring forms and a letter of competence from their surgical proctor to the robotic surgery governance group. Full accreditation will be granted to the submitting surgeon after a satisfactory audit of outcomes of the first 10 cases has been reviewed and approved by the RSGG. Where the necessary expertise is not available locally, audited outcomes will be submitted to a national or international expert for review as required.

Appendix 2

Robotic Training Pathway

Phase 1 – Introduction to Da Vinci Technology

Case Observation/Test Drive
Review procedure videos

Phase 2 – Intuitive Technology Training

Online training modules (2 hours), intuitive comprehensive system training (4 hours)
Online Assessment
Dry skills/suturing training (approx. 2 hours)
Skill simulation (approx. 30-40 hours) 90%
TR100/200 Wetlab training (offsite EU training centre)

Phase 3 – Initial Case Series Plan

Simple case series 5-10 proctored cases
(Patient selection: low BMI, few comorbidities, no previous surgery, low-grade tumours etc.)
Initial case series + proctors to be booked in advance of wetlab attendance
Simple independent case series 5-10 cases

Phase 4 – Continuing Development

TR300 (where available) Advanced procedure specific training
Advanced case series 5+ proctored cases (with patient selection)
Advanced cases + proctors booked in advance of TR300 attendance
On-going proctoring at discretion of surgeon as and when case complexity increases

Proctor 'Sign Off'

APPENDIX 3 – Net Present Costs

Option B -NHSFV patients referred to another board	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Capital - one-offs									
Total Robot capital costs	-								-
Total Decontamination capital costs	-								-
Total	-	-	-	-	-	-	-	-	-
Revenue - one-offs									
Initial Robot Instrumentation & Trays	80,000								80,000
Optimsim bias	8,000								8,000
Total	**88,000**	-	-	-	-	-	-	-	**88,000**
Revenue - On-going									
Savings - staff redeployed	-	482,975	- 482,975	- 482,975	- 482,975	- 482,975	- 482,975	- 482,975	- 3,380,827
Payments to other NHS Board		2,091,115	3,659,451	4,182,230	4,182,230	4,182,230	4,182,230	4,182,230	26,661,716
Optimism bias		209,112	365,945	418,223	418,223	418,223	418,223	418,223	2,666,172
Total	-	**1,817,251**	**3,542,421**	**4,117,478**	**4,117,478**	**4,117,478**	**4,117,478**	**4,117,478**	**25,947,061**
Grand Total Cash Flow	**88,000**	**1,817,251**	**3,542,421**	**4,117,478**	**4,117,478**	**4,117,478**	**4,117,478**	**4,117,478**	**26,035,061**
Discount Rate		3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	
Discounted Cash Flow	**88,000**	**1,755,798**	**3,306,888**	**3,713,729**	**3,588,144**	**3,466,806**	**3,349,571**	**3,236,300**	***22,505,236***
Net Present Cost	**22,505,236**								

Option C - NHSFV surgeon operating in another board	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Capital - one-offs									
Total Robot capital costs	-								-
Total Decontamination capital costs	-								-
Total	-	-	-	-	-	-	-	-	-
Revenue - one-offs									
Initial Robot Instrumentation & Trays	80,000								80,000
Optimism bias	8,000								8,000
Total	**88,000**	-	-	-	-	-	-	-	**88,000**
Revenue - On-going									
Payments to other Nhs Board		1,982,953	3,470,168	3,965,906	3,965,906	3,965,906	3,965,906	3,965,906	25,282,651
Oncall accommodaton FV consultant		17,600	30,800	35,200	35,200	35,200	35,200	35,200	224,400
Consultant travel		2,074	4,147	4,838	4,838	4,838	4,838	4,838	30,413
Cover/Backfill for FV consultant		258,926	517,852	517,852	517,852	517,852	517,852	517,852	3,366,036
Laparoscopic consumables saving		(300,317)	(525,555)	(600,634)	(600,634)	(600,634)	(600,634)	(600,634)	(3,829,042)
Optimism bias		196,124	349,741	392,316	392,316	392,316	392,316	392,316	2,507,446
									-
Total	-	**2,157,359**	**3,847,153**	**4,315,478**	**4,315,478**	**4,315,478**	**4,315,478**	**4,315,478**	**27,581,904**
Grand Total Cash Flow	**88,000**	**2,157,359**	**3,847,153**	**4,315,478**	**4,315,478**	**4,315,478**	**4,315,478**	**4,315,478**	**27,669,904**
Discount Rate		3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	
Discounted Cash Flow	**88,000**	**2,084,405**	**3,591,358**	**3,892,314**	**3,760,690**	**3,633,517**	**3,510,644**	**3,391,927**	***23,952,856***
Net Present Cost	**23,952,856**								

APPENDIX 3 – Net Present Costs (continued)

Option D1 - NHSFV Robot Lease	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Capital - one-offs									
Equipment Lease (IFRS 16)									-
Airseal Insufflation System	12,000								12,000
4K screens	4,000								4,000
Theatre operating table (robot compatable)	77,000								77,000
8 mm Endoscope plus x2	53,486								53,486
8 mm Endoscope sterilisation trays x2	2,143								2,143
Total Decontamination capital costs	150,400								150,400
Optimism bias	29,903								29,903
Total	**328,933**	-	-	-	-	-	-	-	**328,933**
Revenue - one-offs									
Initial Robot Instrumentation & Trays	200,000								200,000
Supplier initial credit	(125,000)								(125,000)
Surgeon training		106,851							106,851
Theatre staffing		46,319							46,319
Offsite decontamination		29,908							29,908
Optimism bias	7,500	18,308	-	-	-	-	-	-	25,808
Total	**82,500**	**201,387**	**-**	**-**	**-**	**-**	**-**	**-**	**283,887**
Revenue - On-going									
Maintenance Lease		177,943	177,943	177,943	177,943	177,943	177,943	177,943	1,245,600
Lease payments		321,665	321,665	321,665	321,665	321,665	321,665	321,665	2,251,656
Sim Now software subscription		-	16,200	16,200	16,200	16,200	16,200	16,200	97,200
Sterilisation Staff		60,163	80,217	80,217	80,217	80,217	80,217	80,217	541,465
Medical physics		14,377	14,377	14,377	14,377	14,377	14,377	14,377	100,638
Maintenance & support of sterilisers		13,655	27,309	27,309	27,309	27,309	27,309	27,309	177,509
Sterilisation consumables		21,166	39,051	44,629	44,629	44,629	44,629	44,629	283,362
Robot drapes and supports		27,080	94,780	108,320	108,320	108,320	108,320	108,320	663,460
Robotic instruments		353,314	618,300	706,628	706,628	706,628	706,628	706,628	4,504,754
Endoscope repairs		7,500	10,000	15,000	15,000	15,000	15,000	15,000	92,500
Reduction Theatre Staff		-	-	(42,532)	(42,532)	(42,532)	(42,532)	(42,532)	(212,658)
		996,862	**1,399,841**	**1,469,756**	**1,469,756**	**1,469,756**	**1,469,756**	**1,469,756**	**9,745,485**
Laparoscopic instrumentation reduction		(300,317)	(525,555)	(600,634)	(600,634)	(600,634)	(600,634)	(600,634)	(3,829,040)
Total	**-**	**696,545**	**874,287**	**869,123**	**869,123**	**869,123**	**869,123**	**869,123**	**5,916,444**
Optimisim bias		69,655	87,429	86,912	86,912	86,912	86,912	86,912	591,644
Grand Total Cash Flow	**411,433**	**967,587**	**961,715**	**956,035**	**956,035**	**956,035**	**956,035**	**956,035**	**7,120,908**
Discount Rate		3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	
Discounted Cash Flow	**411,433**	**934,866**	**897,771**	**862,289**	**833,129**	**804,956**	**777,735**	**751,435**	***6,273,613***
Net Present Cost	**6,273,613**								

APPENDIX 3 – Net Present Costs (continued)

Option D2 - NHSFV Robot Pay As You Go	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Capital - one-offs									
Airseal Insufflation System	12,000								12,000
4K screens	4,000								4,000
Theatre operating table (robot compatable)	77,000								77,000
8 mm Endoscope plus x2	53,486								53,486
8 mm Endoscope sterilisation trays x2	2,143								2,143
Total Decontamination capital costs	150,400								150,400
Optimism bias	29,903								29,903
Total	**328,933**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**328,933**
Revenue - one-offs									
Initial Robot Instrumentation & Trays	200,000								200,000
Supplier initial credit									-
Surgeon training		106,851							106,851
Theatre staffing		46,319							46,319
Offsite decontamination		29,908							29,908
Optimism bias	20,000	18,308	-	-	-	-	-	-	38,308
Total	**220,000**	**201,387**	**-**	**-**	**-**	**-**	**-**	**-**	**421,387**
Revenue - On-going									
Equipment Lease		380,390	380,390	380,390	380,390	380,390	380,390	380,390	2,662,733
Maintenance Lease	-	39,014	217,018	302,362	302,362	302,362	302,362	110,338	1,497,787
Sim Now software subscription		-	16,200	16,200	16,200	16,200	16,200	16,200	97,200
Sterilisation Staff		60,163	80,217	80,217	80,217	80,217	80,217	80,217	541,465
Medical physics		14,377	14,377	14,377	14,377	14,377	14,377	14,377	100,638
Maintenance & support of sterilisers		13,655	27,309	27,309	27,309	27,309	27,309	27,309	177,509
Sterilisation consumables		21,166	39,051	44,629	44,629	44,629	44,629	44,629	283,362
Robot drapes and supports		27,080	94,780	108,320	108,320	108,320	108,320	108,320	663,460
Robotic instruments		353,314	618,300	706,628	706,628	706,628	706,628	706,628	4,504,754
Endoscope repairs		7,500	10,000	15,000	15,000	15,000	15,000	15,000	92,500
Reduction Theatre Staff		-	-	(42,532)	(42,532)	(42,532)	(42,532)	(42,532)	(212,658)
		838,630	**1,497,641**	**1,652,900**	**1,652,900**	**1,652,900**	**1,652,900**	**1,460,876**	**10,408,749**
Laparoscopic instrumentation reduction		(300,317)	(525,555)	(600,634)	(600,634)	(600,634)	(600,634)	(600,634)	(3,829,040)
Total	**-**	**538,313**	**972,087**	**1,052,267**	**1,052,267**	**1,052,267**	**1,052,267**	**860,243**	**6,579,708**
Optimism bias		53,831	97,209	105,227	105,227	105,227	105,227	86,024	657,971
Grand Total Cash Flow	**548,933**	**793,531**	**1,069,295**	**1,157,493**	**1,157,493**	**1,157,493**	**1,157,493**	**946,267**	**7,987,999**
Discount Rate		3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	
Discounted Cash Flow	**548,933**	**766,697**	**998,199**	**1,043,993**	**1,008,688**	**974,578**	**941,621**	**743,757**	***7,026,466***
Net Present Cost	**7,026,466**								

APPENDIX 3 – Net Present Costs (continued)

Option D3 - NHSFV Robot Capital Purchase	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Capital - one-offs									
Total Robot capital costs	2,060,000								2,060,000
Airseal Insufflation System	12,000								12,000
4K screens	4,000								4,000
Theatre operating table (robot compatable)	77,000								77,000
8 mm Endoscope plus x2	53,486								53,486
8 mm Endoscope sterilisation trays x2	2,143								2,143
Total Decontamination capital costs	150,400								150,400
Optimism bias	235,903								235,903
Total	**2,594,933**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**2,594,933**
Revenue - one-offs									
Initial Robot Instrumentation & Trays	200,000								200,000
Supplier initial credit	(125,000)								(125,000)
Surgeon training		106,851							106,851
Theatre staffing		46,319							46,319
Offsite decontamination		29,908							29,908
Optimism bias	7,500	18,308	-	-	-	-	-	-	25,808
Total Non-Recurring	**82,500**	**201,387**	**-**	**-**	**-**	**-**	**-**	**-**	**283,887**
Revenue - On-going									
Maintenance Lease		-	177,000	177,000	177,000	177,000	177,000	177,000	1,062,000
Sim Now software subscription		-	16,200	16,200	16,200	16,200	16,200	16,200	97,200
Sterilisation Staff		60,163	80,217	80,217	80,217	80,217	80,217	80,217	541,465
Medical physics		14,377	14,377	14,377	14,377	14,377	14,377	14,377	100,638
Reduction Theatre Staff (1 wte B3)		-	-	(42,532)	(42,532)	(42,532)	(42,532)	(42,532)	- 212,658
Maintenance & support of sterilisers		13,655	27,309	27,309	27,309	27,309	27,309	27,309	177,509
Sterilisation consumables		21,166	39,051	44,629	44,629	44,629	44,629	44,629	283,362
Endoscope repairs		7,500	10,000	15,000	15,000	15,000	15,000	15,000	92,500
Robot drapes and supports		27,080	94,780	108,320	108,320	108,320	108,320	108,320	663,460
Cost excluding instrumentation		**143,940**	**458,934**	**440,520**	**440,520**	**440,520**	**440,520**	**440,520**	**2,805,475**
Robotic instruments		353,314	618,300	706,628	706,628	706,628	706,628	706,628	4,504,754
Laparoscopic instrumentation reduction		(300,317)	(525,555)	(600,634)	(600,634)	(600,634)	(600,634)	(600,634)	(3,829,040)
Net increase in instrumentation		**52,997**	**92,745**	**105,994**	**105,994**	**105,994**	**105,994**	**105,994**	**675,713**
Optimism bias		**19,694**	**55,168**	**54,651**	**54,651**	**54,651**	**54,651**	**54,651**	**348,119**
Total	-	**216,631**	**606,846**	**601,166**	**601,166**	**601,166**	**601,166**	**601,166**	**3,829,307**
Grand Total Cash Flow	**2,677,433**	**418,018**	**606,846**	**601,166**	**601,166**	**601,166**	**601,166**	**601,166**	**6,708,127**
Discount Rate		3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	
Discounted Cash Flow	**2,677,433**	**403,882**	**566,498**	**542,217**	**523,881**	**506,166**	**489,049**	**472,511**	***6,181,636***
Net Pressent Cost	**6,181,636**								

Appendix 3 – Capital and Revenue cost estimate

Option B -NHSFV patients referred to another board	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Capital - one-offs									
Total Robot capital costs	-								-
Total Decontamination capital costs	-								-
Total	-	-	-	-	-	-	-	-	-
Revenue - one-offs									
Initial Robot Instrumentation & Trays	80,000								80,000
Optimsim bias	8,000								8,000
Total	**88,000**	-	-	-	-	-	-	-	**88,000**
Revenue - On-going									
Savings - staff redeployed	-	482,975	- 482,975	- 482,975	- 482,975	- 482,975	- 482,975	- 482,975	- 3,380,827
Payments to other NHS Board		2,164,304	3,732,640	4,265,875	4,351,192	4,438,216	4,526,980	4,617,520	28,096,727
Optimism bias		216,430	373,264	426,587	435,119	443,822	452,698	461,752	2,809,673
Total	-	**1,897,759**	**3,622,929**	**4,209,487**	**4,303,336**	**4,399,062**	**4,496,703**	**4,596,297**	**27,525,573**
Total revenue cost	**88,000**	**1,897,759**	**3,622,929**	**4,209,487**	**4,303,336**	**4,399,062**	**4,496,703**	**4,596,297**	**27,613,573**
No of Procedures		200	350	400	400	400	400	400	2550
Cost per Procedure		£9,929	£10,351	£10,524	£10,758	£10,998	£11,242	£11,491	£10,794

Option C - NHSFV surgeon operating in another board	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Capital - one-offs									
Total Robot capital costs	-								-
Total Decontamination capital costs	-								-
Total	-	-	-	-	-	-	-	-	-
Revenue - one-offs									
Initial Robot Instrumentation & Trays	80,000								80,000
Optimism bias	8,000								8,000
Total	**88,000**	-	-	-	-	-	-	-	**88,000**
Revenue - On-going									
Payments to other Nhs Board		2,052,356	3,539,571	4,045,224	4,126,129	4,208,651	4,292,824	4,378,681	26,643,436
Oncall accommodaton FV consultant		17,600	31,416	35,904	36,622	37,355	38,102	38,864	235,862
Consultant travel		2,074	4,230	4,935	5,034	5,135	5,237	5,342	31,987
Cover/Backfill for FV consultant		258,926	533,387	533,387	549,389	565,871	582,847	600,332	3,624,139
Laparoscopic consumables saving		(300,317)	(536,066)	(612,647)	(624,900)	(637,398)	(650,146)	(663,148)	(4,024,621)
Optimism bias		203,064	357,254	400,680	409,227	417,961	426,886	436,007	2,651,080
									-
Total	-	**2,233,703**	**3,929,792**	**4,407,484**	**4,501,501**	**4,597,575**	**4,695,751**	**4,796,077**	**29,161,883**
Total revenue cost	**88,000**	**2,233,703**	**3,929,792**	**4,407,484**	**4,501,501**	**4,597,575**	**4,695,751**	**4,796,077**	**29,249,883**
No of Procedures		200	350	400	400	400	400	400	2550
Cost per Procedure		£11,609	£11,228	£11,019	£11,254	£11,494	£11,739	£11,990	£11,436

Appendix 3 – Capital and Revenue cost estimate (continued)

Option D1 - NHSFV Robot Lease	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Capital - one-offs									
Equipment Lease (IFRS 16)	1,937,761								1,937,761
Airseal Insufflation System	12,000								12,000
4K screens	4,000								4,000
Theatre operating table (robot compatable)	77,000								77,000
8 mm Endoscope plus x2	53,486								53,486
8 mm Endoscope sterilisation trays x2	2,143								2,143
Total Decontamination capital costs	150,400								150,400
Optimism bias	223,679								223,679
Total Capital	**2,460,470**	-	-	-	-	-	-	-	**2,460,470**
Revenue - one-offs									
Initial Robot Instrumentation & Trays	200,000								200,000
Supplier initial credit	(125,000)								(125,000)
Surgeon training		106,851							106,851
Theatre staffing		46,319							46,319
Offsite decontamination		29,908							29,908
Optimism bias	7,500	18,308	-	-	-	-	-	-	25,808
Total non-recurring revenue	**82,500**	**201,387**	-	-	-	-	-	-	**283,887**
Revenue - On-going									
Maintenance Lease		177,943	181,502	185,132	188,834	192,611	196,463	200,393	1,322,877
Capital charges/depreciation		276,823	276,823	276,823	276,823	276,823	276,823	276,823	1,937,761
Finance interest		85,976	73,438	60,232	46,324	31,676	16,248	- 0	313,894
Sim Now software subscription		-	16,200	16,524	16,854	17,192	17,535	17,886	102,192
Sterilisation Staff		60,163	82,624	85,102	87,655	90,285	92,994	95,783	594,606
Medical physics		14,377	14,808	15,252	15,710	16,181	16,667	17,167	110,162
Maintenance & support of sterilisers		13,655	27,855	28,412	28,981	29,560	30,151	30,754	189,368
Sterilisation consumables		21,166	39,832	45,522	46,432	47,361	48,308	49,274	297,894
Robot drapes and supports		27,080	96,676	110,486	112,696	114,950	117,249	119,594	698,731
Robotic instruments		353,314	630,665	720,761	735,176	749,879	764,877	780,174	4,734,846
Endoscope repairs		7,500	10,200	15,300	15,606	15,918	16,236	16,561	97,322
Reduction Theatre Staff		-	-	(45,122)	(46,475)	(47,870)	(49,306)	(50,785)	(239,557)
		1,037,996	**1,450,622**	**1,514,425**	**1,524,616**	**1,534,566**	**1,544,246**	**1,553,625**	**10,160,096**
Laparoscopic instrumentation reduction		(300,317)	(536,066)	(612,646)	(624,899)	(637,397)	(650,145)	(663,148)	(4,024,619)
Sub total recurring revenue		**737,679**	**914,557**	**901,778**	**899,717**	**897,169**	**894,101**	**890,477**	**6,135,477**
Optimisim bias		73,768	91,456	90,178	89,972	89,717	89,410	89,048	613,548
Total recurring revenue		**811,447**	**1,006,012**	**991,956**	**989,688**	**986,886**	**983,511**	**979,524**	**6,749,024**
No of Procedures		200	350	400	400	400	400	400	2550
Cost per Procedure		£5,108	£2,874	£2,480	£2,474	£2,467	£2,459	£2,449	£2,647

Appendix 3 – Capital and Revenue cost estimate (continued)

Option D2 - NHSFV Robot Pay As You Go	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Capital - one-offs									
Airseal Insufflation System	12,000								12,000
4K screens	4,000								4,000
Theatre operating table (robot compatable)	77,000								77,000
8 mm Endoscope plus x2	53,486								53,486
8 mm Endoscope sterilisation trays x2	2,143								2,143
Total Decontamination capital costs	150,400								150,400
Optimism bias	29,903								29,903
Total capital	**328,933**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**328,933**
Revenue - one-offs									
Initial Robot Instrumentation & Trays	200,000								200,000
Supplier initial credit									-
Surgeon training		106,851							106,851
Theatre staffing		46,319							46,319
Offsite decontamination		29,908							29,908
Optimism bias	20,000	18,308	-	-	-	-	-	-	38,308
Total non-recurring revenue	**220,000**	**201,387**	**-**	**-**	**-**	**-**	**-**	**-**	**421,387**
Revenue - On-going									
Equipment Lease		380,390	387,998	395,758	403,673	411,747	419,982	428,381	2,827,930
Maintenance Lease	-	39,014	217,018	308,409	314,577	320,869	327,286	124,258	1,573,401
Sim Now software subscription		-	16,200	16,524	16,854	17,192	17,535	17,886	102,192
Sterilisation Staff		60,163	82,624	85,102	87,655	90,285	92,994	95,783	594,606
Medical physics		14,377	14,808	15,252	15,710	16,181	16,667	17,167	110,162
Maintenance & support of sterilisers		13,655	27,855	28,412	28,981	29,560	30,151	30,754	189,368
Sterilisation consumables		21,166	39,832	45,522	46,432	47,361	48,308	49,274	297,894
Robot drapes and supports		27,080	96,676	110,486	112,696	114,950	117,249	119,594	698,731
Robotic instruments		353,314	630,665	720,761	735,176	749,879	764,877	780,174	4,734,846
Endoscope repairs		7,500	10,200	15,300	15,606	15,918	16,236	16,561	97,322
Reduction Theatre Staff		-	-	(45,122)	(46,475)	(47,870)	(49,306)	(50,785)	(239,557)
		838,630	**1,523,876**	**1,696,405**	**1,730,885**	**1,766,072**	**1,801,979**	**1,629,049**	**10,986,895**
Laparoscopic instrumentation reduction		(300,317)	(536,066)	(612,646)	(624,899)	(637,397)	(650,145)	(663,148)	(4,024,619)
Sub total recurring revenue		**538,313**	**987,810**	**1,083,758**	**1,105,986**	**1,128,674**	**1,151,834**	**965,900**	**6,962,276**
Optimism bias		53,831	98,781	108,376	110,599	112,867	115,183	96,590	696,228
Total recurring revenue		**592,145**	**1,086,591**	**1,192,134**	**1,216,584**	**1,241,542**	**1,267,017**	**1,062,491**	**7,658,503**
No of Procedures		200	350	400	400	400	400	400	2550
Cost per Procedure		£4,799	£3,105	£2,980	£3,041	£3,104	£3,168	£2,656	£3,003

Appendix 3 – Capital and Revenue cost estimate (continued)

Option D3 - NHSFV Robot Capital Purchase	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Capital - one-offs									
Total Robot capital costs	2,060,000								2,060,000
Airseal Insufflation System	12,000								12,000
4K screens	4,000								4,000
Theatre operating table (robot compatable)	77,000								77,000
8 mm Endoscope plus x2	53,486								53,486
8 mm Endoscope sterilisation trays x2	2,143								2,143
Total Decontamination capital costs	150,400								150,400
Optimism bias	235,903								235,903
Total capital	**2,594,933**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**2,594,933**
Revenue - one-offs									
Initial Robot Instrumentation & Trays	200,000								200,000
Supplier initial credit	(125,000)								(125,000)
Surgeon training		106,851							106,851
Theatre staffing		46,319							46,319
Offsite decontamination		29,908							29,908
Optimism bias	7,500	18,308	-	-	-	-	-	-	25,808
Total Non-Recurring Revenue	**82,500**	**201,387**	**-**	**-**	**-**	**-**	**-**	**-**	**283,887**
Revenue - On-going									
Maintenance Lease		-	177,000	180,540	184,151	187,834	191,590	195,422	1,116,537
Capital charges/depreciation		294,286	294,286	294,286	294,286	294,286	294,286	294,286	2,060,000
Sim Now software subscription		-	16,200	16,524	16,854	17,192	17,535	17,886	102,192
Sterilisation Staff		60,163	82,624	85,102	87,655	90,285	92,994	95,783	594,606
Medical physics		14,377	14,808	15,252	15,710	16,181	16,667	17,167	110,162
Reduction Theatre Staff (1 wte B3)		-	-	(45,122)	(46,475)	(47,870)	(49,306)	(50,785)	- 239,557
Maintenance & support of sterilisers		13,655	27,309	27,309	27,309	27,309	27,309	27,309	177,509
Sterilisation consumables		21,166	39,832	45,522	46,432	47,361	48,308	49,274	297,894
Endoscope repairs		7,500	10,200	15,300	15,606	15,918	16,236	16,561	97,322
Robot drapes and supports		27,080	96,676	110,486	112,696	114,950	117,249	119,594	698,731
Cost excluding instrumentation		**438,226**	**758,934**	**745,200**	**754,224**	**763,446**	**772,869**	**782,498**	**5,015,395**
Robotic instruments		353,314	630,665	720,761	735,176	749,879	764,877	780,174	4,734,846
Laparoscopic instrumentation reduction		(300,317)	(536,066)	(612,646)	(624,899)	(637,397)	(650,145)	(663,148)	(4,024,619)
Net increase in instrumentation		**52,997**	**94,600**	**108,114**	**110,276**	**112,482**	**114,732**	**117,026**	**710,227**
Optimism bias		**49,122**	**85,353**	**85,331**	**86,450**	**87,593**	**88,760**	**89,952**	**572,562**
Total recurring revenue		**540,345**	**938,887**	**938,645**	**950,950**	**963,520**	**976,360**	**989,476**	**6,298,184**
No of Procedures		200	350	400	400	400	400	400	2550
Cost per Procedure		£4,121	£2,683	£2,347	£2,377	£2,409	£2,441	£2,474	£2,470

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Forth Valley Royal Hospital

da Vinci Value for Money 2025

Intuitive confidential information – Intuitive internal use only – may not be shared or distributed.

Principles used for analysis

- Forward analysis of the impact of da Vinci at Forth Valley Royal Hospital
- Outcome data for open/ Lap/ dV provided by surgeon and aligned with HES data for dV
- Analysis on the impact of moving open surgery and lap surgery to da Vinci RAS to improve patient care
- Cost avoidance / value for money analysis

Intuitive confidential information – Intuitive internal use only – may not be shared or distributed.

Forth Valley Royal Hospital da Vinci Procedures forecast

Category	Procedure	Patient Clinical Opportunity	Annual Patient Volume	Conversion to dV							Total Open/Lap Patients	Total Patients Converted to dV	7-Year Annualized dV Patients
				Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7			
Totals			434	168	232	331	331	331	331	331	3038	2053	293
General	Colon Resection	Existing Open Cases	20	10 50%	15 75%	16 80%	16 80%	16 80%	16 80%	16 80%	140	105	15
General	Colon Resection	Existing Lap Cases	170	85 50%	128 75%	136 80%	136 80%	136 80%	136 80%	136 80%	1,190	893	128
General	Rectal Resection	Existing Open Cases	6	3 50%	5 75%	5 80%	5 80%	5 80%	5 80%	5 80%	42	32	5
General	Rectal Resection	Existing Lap Cases	30	15 50%	23 75%	24 80%	24 80%	24 80%	24 80%	24 80%	210	158	23
General	Incisional Hernia	Existing Open Cases	20	5 25%	10 50%	8 40%	8 40%	8 40%	8 40%	8 40%	140	55	8
General	Incisional Hernia	Existing Lap Cases	20	5 25%	10 50%	8 40%	8 40%	8 40%	8 40%	8 40%	140	55	8
Urology	Nephrectomy	Existing Open Cases	10	0	3 25%	8 75%	8 75%	8 75%	8 75%	8 75%	70	40	6
Urology	Nephrectomy	Existing Open Cases	40	0	10 25%	32 80%	32 80%	32 80%	32 80%	32 80%	280	170	24
Gynaecology	Hysterectomy - Benign	Existing Open Cases	29	0	7 25%	23 80%	23 80%	23 80%	23 80%	23 80%	203	123	18
Gynaecology	Hysterectomy - Benign	Existing Lap Cases	65	33 50%	16 25%	52 80%	52 80%	52 80%	52 80%	52 80%	455	309	44
Gynaecology	Hysterectomy - Malignant	Existing Open Cases	2	1 50%	1 25%	2 80%	2 80%	2 80%	2 80%	2 80%	14	10	1
Gynaecology	Hysterectomy - Malignant	Existing Lap Cases	22	11 50%	6 25%	18 80%	18 80%	18 80%	18 80%	18 80%	154	105	15

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Forth Valley Royal Hospital Metrics for Analysis

Metrics for Cost Avoidance Analysis		Metrics for Existing Open/Lap Cases								Metrics for dV Cases							
Procedure	**Patient Clinical Opportunity**	**Avg. LOS**	**% Conversions**	**% Complications**	**% 30 Day Readmission**	**% Blood Transfusion**	**Theatre Room Time (Minutes)**	**Critical Care Admission %**	**Outcome Data Reference**	**Avg. LOS**	**% Conversions**	**% Complications**	**% 30 Day Readmission**	**% Blood Transfusion**	**Theatre Room Time (Minutes)**	**Critical Care Admission %**	**Outcome Data Reference**
Colon Resection	Existing Open Cases	**8.0**	**0%**	**36%**	**6%**				**Hospital Data**	**1.0**	**0.0%**	**15.0%**	**4.5%**	**no data**	**no data**		**Greg Ekatah (QTI)**
Colon Resection	Existing Lap Cases	**4.0**	**6%**	**16%**	**5%**				**Hospital Data**	**1.0**	**3.0%**	**15.0%**	**4.5%**	**no data**	**no data**		**Greg Ekatah (QTI)**
Rectal Resection	Existing Open Cases	**8.0**	**0%**	**32%**	**6%**				**Hospital Data**	**3.0**	**0.0%**	**2.0%**	**4.5%**	**no data**	**no data**		**Greg Ekatah (QTI)**
Rectal Resection	Existing Lap Cases	**4.0**	**6%**	**19%**	**6%**				**Hospital Data**	**3.0**	**0.0%**	**2.0%**	**4.5%**	**no data**	**no data**		**Greg Ekatah (QTI)**
Incisional Hernia	Existing Open Cases	**4.3**	**0%**	**16%**	**13%**				**Reference**	**1.4**	**0.6%**	**14.0%**	**1.9%**	**no data**	**no data**		**HES Data**
Incisional Hernia	Existing Lap Cases	**3.7**	**13%**	**13%**	**12%**				**Reference**	**1.4**	**0.6%**	**14.0%**	**1.9%**	**no data**	**no data**		**HES Data**
Nephrectomy	Existing Open Cases	**7.0**	**0%**	**37%**	**14%**				**Reference**	**2.0**	**1.0%**	**21.0%**	**0.0%**	**no data**	**no data**		**Puller (QTI)**
Nephrectomy	Existing Open Cases	**3.0**	**4%**	**20%**	**12%**				**Reference**	**2.0**	**1.0%**	**21.0%**	**0.0%**	**no data**	**no data**		**Puller (QTI)**
Hysterectomy - Benign	Existing Open Cases	**2.5**	**0%**	**16%**	**8%**				**Hospital Data**	**1.0**	**0.0%**	**0.6%**	**0.0%**	**no data**	**no data**		**Raza (QTI)**
Hysterectomy - Benign	Existing Lap Cases	**1.7**	**9%**	**3%**	**8%**				**Hospital Data**	**1.0**	**0.0%**	**0.6%**	**0.0%**	**no data**	**no data**		**Raza (QTI)**
Hysterectomy - Malignant	Existing Open Cases	**2.5**	**0%**	**22%**	**8%**				**Hospital Data**	**1.0**	**0.0%**	**5.0%**	**2.0%**	**no data**	**no data**		**Lipiatt (QTI)**
Hysterectomy - Malignant	Existing Lap Cases	**1.7**	**9%**	**24%**	**8%**				**Hospital Data**	**1.0**	**0.0%**	**5.0%**	**2.0%**	**no data**	**no data**		**Lipiatt (QTI)**

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Forth Valley Royal Hospital Metrics for Analysis

**Based on Hospital data and reference da Vinci data*

Surgical Bed Capacity Analysis & Incremental da Vinci Patients Treated

Procedure	Patient Source	Est. Annual Open/Lap Cases	Est. Annual Open/Lap Patients Converted to dV	Annual Bed Days Avoided	Potential Incremental dV Patients	% of Potential dV patients that could be treated	Number of Incremental dV patients that could be treated
TOTALS		**434**	**294**	**695**	**626**		**156**
Colon Resection	Existing Open Cases	20	15	105	105	25%	**26**
Colon Resection	Existing Lap Cases	170	128	383	383	25%	**96**
Rectal Resection	Existing Open Cases	6	5	23	8	25%	**2**
Rectal Resection	Existing Lap Cases	30	23	23	8	25%	**2**
Incisional Hernia	Existing Open Cases	20	8	23	16	25%	**4**
Incisional Hernia	Existing Lap Cases	20	8	18	13	25%	**3**
Nephrectomy	Existing Open Cases	10	6	30	15	25%	**4**
Nephrectomy	Existing Lap Cases	40	24	24	12	25%	**3**
Hysterectomy - Benign	Existing Open Cases	29	18	26	26	25%	**7**
Hysterectomy - Benign	Existing Lap Cases	65	44	29	29	25%	**7**
Hysterectomy - Malignant	Existing Open Cases	2	1	2	2	25%	**1**
Hysterectomy - Malignant	Existing Lap Cases	22	15	10	10	25%	**2**

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Forth Valley Royal Hospital - Clinical Cost Benefit Analysis

*Based on Hospital Forth Valley Royal Hospital Surgeon data

MACA | Market Access & Custom Analytics

Open and Lap Procedures Converted to da Vinci

Estimated da Vinci Financial Clinical Cost Avoidance Analysis (£ GBP)

Procedure	Patient Source	Est. Annual dV Patients	Length of Stay	Conversions	Complications	30 Day Readmission	Blood Transfusion	Theatre Room Time	Critical Care	Total Cost Avoidance
TOTALS		**294**	**£282,792**	**£26,837**	**£152,744**	**£30,268**	**£0**	**£0**	**£0**	**£492,640**
Colon Resection	Existing Open Cases	15	£42,735	£0	£40,811	£540			£0	**£84,086**
Colon Resection	Existing Lap Cases	128	£155,678	£8,495	£16,519	£1,530			£0	**£182,222**
Rectal Resection	Existing Open Cases	5	£9,158	£0	£17,491	£162			£0	**£26,810**
Rectal Resection	Existing Lap Cases	23	£9,158	£2,998	£49,557	£810			£0	**£62,523**
Incisional Hernia	Existing Open Cases	8	£9,274	-£105	£975	£2,093			£0	**£12,237**
Incisional Hernia	Existing Lap Cases	8	£7,355	£2,164	-£487	£1,905			£0	**£10,936**
Nephrectomy	Existing Open Cases	6	£12,355	-£135	£4,097	£2,040			£0	**£18,358**
Nephrectomy	Existing Lap Cases	24	£9,884	£1,618	-£1,024	£6,994			£0	**£17,472**
Hysterectomy - Benign	Existing Open Cases	18	£10,749	£0	£9,837	£3,381			£0	**£23,967**
Hysterectomy - Benign	Existing Lap Cases	44	£11,669	£8,817	£3,840	£8,469			£0	**£32,794**
Hysterectomy - Malignant	Existing Open Cases	1	£829	£0	£837	£195			£0	**£1,861**
Hysterectomy - Malignant	Existing Lap Cases	15	£3,949	£2,984	£10,291	£2,150			£0	**£19,374**

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Forth Valley Royal Hospital - Clinical Cost Benefit Analysis

MACA | Market Access & Custom Analytics

*Based on Hospital Forth Valley Royal Hospital Surgeon and reference data

Clinical Value Gained per Yr.

Complications decrease	Readmissions decrease	Conversions decrease	Total clinical cost avoidance
35%	**60%**	**74%**	**£209,849** (Excluding LOS)
£152,744	**£30,268**	**£26,837**	**£492,640** (Including LOS)

Yearly Clinical Benefit by Specialty

Specialty	Avg. LOS decrease	Bed Days Released	Potential Incremental dV Patients	Length of Stay	Conversions	Complications	Total Clinical Cost Avoidance (No LOS)
Total	**2.4**	**695**	**626**	**£282,792**	**£26,837**	**£152,744**	**£209,849**
General	3.1	573	532	£233,356	£13,553	£124,865	£145,458
Urology	1.8	55	27	£22,240	£1,483	£3,073	£13,591
Gynaecology	0.9	67	67	£27,196	£11,801	£24,805	£50,800

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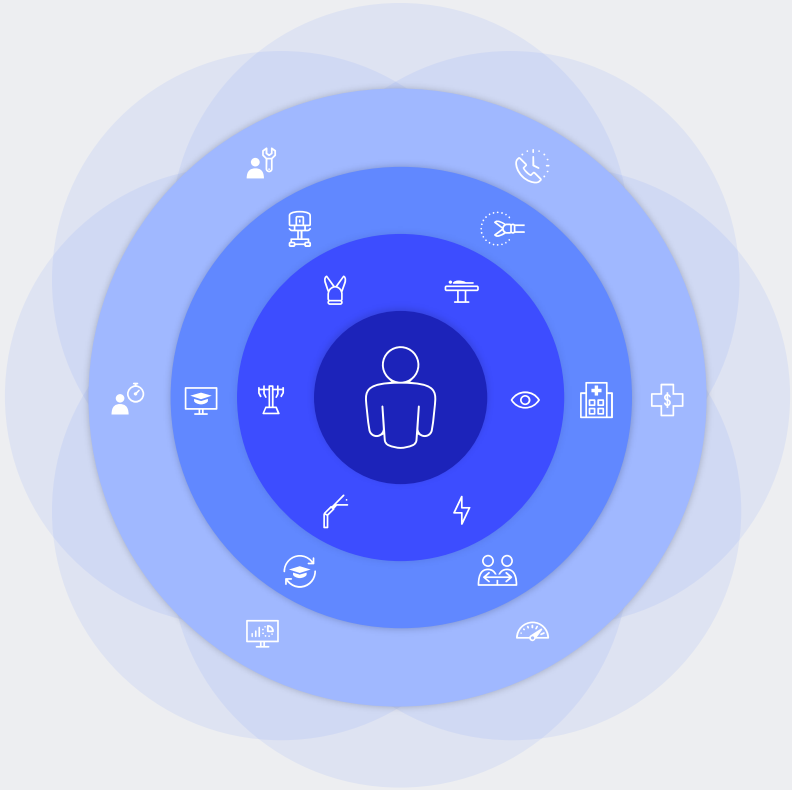
What you can expect from us



A connected ecosystem

- Patients, surgeons, and hospitals
- Innovation and integration
- Training and education
- Support and analytics

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NHS Forth Valley

Forth Valley NHS Board

10. Corporate Objectives Progress Update
Purpose: This report is for Assurance

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Kerry Mackenzie, Acting Director of Strategic Planning & Performance

Executive Summary

This paper provides an in-year update on progress made in the delivery of the Corporate Objectives 2025/26 through the Programme Board structure.

Action Required

The Forth Valley NHS Board is asked to:

(1) consider the progress made in the delivery of the Corporate Objectives 2025/26.
(2) request a further update reflecting the year end position and lessons learned noting biannual progress updates will be scheduled in 2026/27.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This matter has previously been considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- The Senior Leadership Team met in November 2025 to review progress with the Corporate Objectives 2025/26 with all programme boards presenting.
- The Remuneration Committee received a progress update in December 2025 aligned to the Executive and Senior Manager objectives.

Risk Assessment and Mitigation

A standardised risk report is being developed for each programme board as part of the delivery structure which will be used to escalate delivery risks to the Senior Leadership Team, NHS Forth Valley Board and the relevant governance committees where required. Linkage to organisational and strategic risks is being undertaken to ensure a system-wide view not only of the risks to delivery of the programme but also the potential impacts organisationally and strategically.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial, Digital and Infrastructure Implications

There are no direct financial, digital and infrastructure implications in respect of this paper. Any implications will be addressed through the workstreams linked to the programme boards.

Workforce Implications
There are no direct workforce implications in relation to this paper. Any implications will be addressed through the workstreams linked to the programme boards.

Quality / Patient Care Implications
There are no direct quality / patient care implications in relation to this paper. Any implications will be addressed through the workstreams linked to the programme boards.

Population Health & Care Strategy
Delivery our Corporate Objectives directly link to the prioritisation of activities required to deliver our Population Health & Care Strategy. Effective oversight supports our ongoing strategic delivery aims.

Climate Change / Sustainability Implications
There are no Climate Change / Sustainability Implications in respect of this paper. Any implications will be addressed through the workstreams linked to the programme boards.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

Appendices
Appendix 1 – Corporate Objectives 2025/26 Progress Update

Appendix 1

Corporate Objectives 2025/26 Progress Update

1. Introduction

2025/26 marks the first full cycle of NHS Forth Valley's Programme of Work methodology. This new approach was designed to strengthen organisational delivery by:

- Establishing a streamlined suite of Corporate Objectives.
- Agreeing clear annual deliverables under each objective.
- Setting Executive Objectives to ensure accountability for strategic leadership.
- Implementing a structured governance model through Executive-chaired Programme Boards

The methodology is now fully embedded. All Programme Boards are operational, meeting regularly, and supported by programme plans and clear Terms of Reference.

A system-wide review session with the Senior Leadership Team (SLT) in November assessed performance, identified areas on track, and highlighted where additional support was required. A key learning point is the need to bring next year's SLT review forward to October, enabling earlier visibility of risks to delivery and allowing for more timely escalation to the Strategic Planning Performance & Resources Committee (SPPRC) or NHS Board.

Overall, the Programme of Work approach is driving improved transparency, shared ownership, and cross-organisational collaboration. Progress against each Programme Board portfolio is summarised below.

2. Programme Board Progress Summaries

2.1 Children & Families

Executive Lead: Acting Director of Strategic Planning & Performance

The Children & Families Programme Board has continued to mature significantly following its relaunch in late 2025, demonstrating clearer structure, improved governance, and strengthened alignment to corporate objectives.

Key updates and achievements

- Terms of Reference were finalised, clarifying purpose, scope, governance routes, and key associated groups including Community Planning Partnerships, GIRFEC groups, Best Start, and public protection structures.
- A new, comprehensive Programme Plan has been developed using CPMO delivery tools, with improved tracking and visibility across workstreams.
- The Children and Families Programme Board reviewed a strengthened highlight reporting method, risk log, and action plan structure to ensure consistency and escalation to SLT.
- Multi-agency planning continues on the Children's Population Health & Care Strategic Framework, with alignment across six related plans (children's services plans, poverty plan, mental health and wellbeing strategic plan).
- Ongoing development of both professional and public-facing versions of the Corporate Parenting Plan, ensuring accessibility and compliance with Scottish Government guidance.
- Bairns Hoose project is progressing supported by multi-agency engagement, including professional focus groups and participation work with children and young people. Key outputs include third-sector mapping exercise, data-protection assessment, and trauma-informed staff supervision model.

- Ongoing development of and linkage to the major priority areas of:
  - Paediatric Neurodevelopmental Services
  - Child Poverty and Whole Family Support alignment
  - Children & Young People's Strategic Plan
  - Complex Care and Child & Adolescent Mental Health Service / Neurodevelopmental pathways
  - Sexual Health
  - Immunisation Services

Risks and challenges
- Rising demand pressures in complex care.
- Delivery of a coherent system-wide strategic approach to children's services.
- Strengthened cross-agency collaboration and improved reporting.

Forward focus
- Using the strengthened programme governance to drive delivery and evidence progress.
- Embedding and improving reporting consistency in a structured and planned manner ensuring all relevant stakeholders are involved.

2.2 Financial Stewardship

Executive Lead: Director of Finance
There is an ongoing strengthening of financial grip across the system with the financial stewardship programme continuing to be updated through fortnightly review meetings.

Key updates and achievements
- The most recent finance report confirms that although the organisation was forecasting a £5m overspend in November 2025, the outlook has subsequently improved to a break-even position, supported by revised planning assumptions, confirmed allocations, and strengthened savings plans
- Updated Financial Sustainability Plan remains broadly on track, and historic savings budgets have been removed to strengthen transparency and stewardship.
- Continued roll-out of self-service financial reporting, including PLICS, is on plan, with completion scheduled for March 2026. Tableau vs Power BI remains under review to support longer-term analytics capability.
- Medicines, Infrastructure and Digital subgroups remain active, with clarified governance routes and ongoing links into SPPRC to avoid duplication.
- Finance continues to support the value-based health & care programme by helping establish costing models for value and stewardship.

Forward focus
- Maintaining the trajectory to year-end break-even, recognising emerging risks around IJB year-end positions and risk-sharing arrangements.
- Finalisation of the three-year financial plan, now in development, aligned with the 2026/27 savings programme.

2.3 Quality

Executive Lead: Executive Nurse Director
Ongoing progress across a number of areas including quality, innovation, infection prevention and control, clinical governance and safety improvement.

Key updates and achievements
- Innovation Plan, Realistic Medicine initiatives, infection prevention and control work, and implementation of clinical governance standards progressing well.
- Adverse Event Management Policy approved, with clinical policy governance strengthened.
- SAERS capacity improved, meeting new demand levels, although a sustained backlog reduction plan with business case has still to be ratified.
- Launch of skin cancer and lung cancer clinical trials.
- Significant progress across safety and quality improvement:
    - Safer Together Collaborative
    - Digital dermatology
    - New cancer clinical trials in skin and lung cancer are active.
    - Scottish Patient Safety Programme paediatric and perinatal metrics approved.

Challenges
- Primary care pathway improvement requires further GP engagement.
- Need for clearer alignment between safety reporting and governance structures with work ongoing to address.

FOIs and complaints
- FOI performance remains above 90% for three consecutive months.
- Complaints continue to fall significantly, from approx. 550 to around 160, with focus shifting to stabilising new processes for sustainability.

Forward focus
Ongoing review of alignment to corporate objectives and refinement of priorities to ensure a clear structure, strong governance, and coherent strategic direction.

2.4 Strategic Workforce

Executive Lead: Director of People
The programme board continues to development following its establishment in late 2025, and the shift to more structured reporting arrangements through the governance framework.

Key updates and achievements
- Development of the 2026–27 Workforce Plan update is underway, with an April 2026 submission target. The Board will act as the core assurance mechanism for this process.
- Large increase in requests for work experience placements, with employability workstream activity ahead of plan and apprenticeship pathways being strengthened.
- Programme Board Terms of Reference and reporting formats finalised, alongside the risk register and escalation process.

Risks and challenges
- Lack of a national workforce programme is creating a strong requirement for internal modelling and capability-building.
- Continued pressure from sickness absence, mandatory training variation, and workforce supply challenges, reinforcing the need for a multi-professional approach to vacancy decisions.

Forward focus
- Mobilisation of the full programme plan across workstreams, with scheduled meetings and structured reporting now active.
- Alignment with population health, strategic planning, and service transformation programmes to ensure workforce capability matches future demand.

2.5 Urgent & Unscheduled Care

Executive Lead: Director of Acute
Improvements across key urgent & unscheduled care metrics, particularly in December 2025, though sustained pressures persist.

Key updates and achievements
- December performance improvements include better 4-hour access, reduced length of stay, reduced use of contingency beds, and lower occupancy.
- The ongoing 12-week improvement plan continues to focus on governance, data, workforce, and stabilisation.
- Recruitment activity to address Emergency Department workforce gaps continues, with strengthened leadership in progress.
- Discharge coordinators remain active, and pathway optimisation work is underway.

System improvement
- Adults with Incapacity (Scotland) Act 2000 (AWI) delays have materially reduced in Falkirk HSCP, following strengthened use of legislative frameworks.
- Community frailty pathway remains promising and is recognised as an area of good practice nationally.

Outstanding risks
- Development of a sustainable Flow Navigation Centre model.
- Integrated Discharge Team capability and alignment with HSCPs.
- Delivery of a large system-wide discharge event to create operational learning.

Forward focus
- Continued development of whole-system flow models bridging acute, community, primary care and social care.

2.6 Value Based Health & Care

Executive Lead: Medical Director
Significant organisational momentum noted in preparation for the successful Value Based Health & Care Collaborative Launch on 22 January 2026, with strong leadership engagement and cross-system involvement.

Key updates and achievements
- Final development of the value-based health & care toolkit, designed to provide consistency across transformation programmes.
- Full establishment of project groups for Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMs) and Workforce Reported Experience Measures (WREMs), with digital infrastructure requirements now being defined.
- Pentana based KPI dashboard now operational in early form, tracking engagement, sessions delivered, and system adoption metrics.

- Recruitment plans for additional finance and programme capacity are in development to strengthen value-based health & care financial stewardship.
- Leadership development for triumvirates, manager-clinician-finance leads, is being established to embed value-based health & care consistently across the organisation.

Forward focus

- Scaling value-based health & care through three delivery tiers:
    1. Organisation-wide access to resources
    2. Structured Collaborative cohorts
    3. Targeted leadership development for senior decision-makers
- Expanding KPI tracking and consolidating digital and data infrastructure to support outcome measurement.

3. Conclusion

The introduction of the Programme of Work structure has strengthened our ability to monitor and deliver the Corporate Objectives. Programme Boards are maturing, with improved clarity of purpose, governance, and accountability.

While significant progress is evident across all areas, key system challenges financial sustainability, workforce availability, unscheduled care pressures, and clinical governance backlogs require ongoing prioritisation.

The learning from this first year, including the need for earlier SLT review, will support a more proactive and refined approach in 2026/27, and will be detailed in the year end update. Continued learning and review will ensure that organisational delivery remains focused, transparent, and aligned with strategic priorities.

NHS Forth Valley
Forth Valley NHS Board

11. HIS Unannounced Mental Health Services Safe Delivery of Care Inspection - NHS Forth Valley
Purpose: This report is for Assurance

Executive Sponsor: Karen Goudie, Executive Nurse Director
Author: Lorraine Robertson, Chief Nurse & Ross Cheape, Head of Mental Health & Learning Disability Services

Executive Summary

Healthcare Improvement Scotland (HIS) conducted an unannounced Safe Delivery of Care inspection of Mental Health Services at Forth Valley Royal Hospital, with the observational component of the inspection taking place between 25 and 26 August 2025.

HIS carried out the unannounced inspection to the Mental Health Unit in Forth Valley Royal Hospital using the safe delivery of care inspection methodology. HIS inspected:

- Ward 1
- Ward 2
- Ward 3
- Ward 4
- Ward 5

During the inspection HIS inspected the ward and hospital environment; observed staff practice and interactions with patients, such as during patient mealtimes; spoke with patients, visitors and ward staff; accessed patients' health records, monitoring reports, policies and procedures.

The resulting report was published on 28 January 2026 (Appendix 1) and identified:

- 8 areas of good practice
- 1 recommendation
- 19 requirements

NHS Forth Valley provided HIS with an action plan (Appendix 2) addressing the associated recommendations and requirements. A local action plan has also been developed to ensure that the recommendations and requirements are being addressed accordingly. A summary of progress with this is attached (Appendix 3).

Key Issues Identified

- Adult Support and Protection procedures
- Ligature risk management
- Governance and oversight of safety incidents
- Staffing levels, training and supervision
- The healthcare environment
- Policy compliance and consistency

Action Required

The Forth Valley NHS Board is asked to:

(i) note the findings of the HIS inspection and the associated risks;
(ii) note the proposed action plan addressing HIS recommendations;
(iii) take assurance that the correct actions are in place and being progressed as per timescales, and

(iv) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration
Governance Routes detailed below:

- Mental Health and Learning Disability Clinical Governance Working Group 29th January 2026
- Clackmannanshire and Stirling Health and Social Care Partnership, Senior Leadership Team 4th February 2026
- NHS Forth Valley Clinical Governance Working Group 19th February 2026. Highlighted as part of the MHLD Assurance Report

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Risk Assessment and Mitigation

- **Patient Safety:** Delays in the implementation of HIS recommendations may adversely affect the safe delivery of care.
- **Regulatory Compliance:** Non-compliance with HIS standards and statutory obligations outlined in the Health and Care (Staffing) (Scotland) Act 2019 may lead to referral or escalation to external regulatory bodies.
- **Reputational Impact:** Failure to comply or negative outcomes identified during follow-up inspections may compromise the organisation's credibility and diminish public trust.
- **Immediate Clinical Safeguards:** Ongoing work to enhance reporting and escalation pathways for incidents.
- **Governance Reporting Enhancements:** Oversight has been reinforced with weekly HIS Delivery Group reviews, and revised action logs within the Delivery Tool. Data visualisation is in development and will be central to achieving improvement aims.

Impact Assessments
Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial, Digital and Infrastructure Implications
Financial: Potential for significant capital cost to address built environment issues; revenue impact from workforce adjustments is being calculated and will be presented following financial assessment.
Digital: Safecare implementation for real-time staffing oversight is complete, but utilisation requires further work.
Infrastructure: There is development work on the built environment to remove or mitigate ligature risks, access to roof spaces and to enhance the safety and therapeutic milieu of the environment.

Workforce Implications
The report identifies staffing pressures and training cancellations as risks. Actions aim to improve staff support, leadership time, and workforce sustainability.

Population Health & Care Strategy
The HIS inspection findings and subsequent action plan directly contribute to NHS Forth Valley's Population Health & Care Strategy by strengthening the safety and quality of mental health services.

Climate Change / Sustainability Implications
No direct implications identified.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

Appendices
Appendix 1 – HIS Main Report
Appendix 2 - HIS Action Plan
Appendix 3 – Local Action Plan Summary of Progress

Appendix 1

Unannounced Inspection Report

Mental Health Services Safe Delivery of Care Inspection

Forth Valley Royal Hospital

NHS Forth Valley

25 - 26 August 2025

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About our inspection

Background

The current Healthcare Improvement Scotland Adult Mental Health inspection programme was developed as part of a range of actions to support and improve NHS adult mental health services in Scotland in the context of the COVID-19 pandemic and beyond. Although the initial focus of this work was on Infection Prevention and Control, it was agreed with Scottish Government to broaden the inspection focus from infection prevention and control to a broader assurance function, creating a new and revised 'safe delivery of care' assurance model in NHS adult mental health units.

Our revised methodology will incorporate the HIS Quality Assurance System Quality Assurance Framework and will consider a wide range of standards such as the Health and Social Care Standards (2017) and the new Core Mental Health Quality Standards and indicators (2024)

Further information about the methodology for adult mental health inpatient services safe delivery of care inspections can be found on our website.

Our Focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About the hospital we inspected

The Mental Health Unit within Forth Valley Royal Hospital consists of five wards covering the Stirling, Falkirk and Clackmannanshire area. This includes provision for adult and older adult mental health assessment, dementia specialist treatment and an intensive psychiatric treatment unit.

About this inspection

We carried out an unannounced inspection to the Mental Health Unit in Forth Valley Royal Hospital, NHS Forth Valley on Monday 25 and Tuesday 26 of August 2025 using our safe delivery of care inspection methodology. We inspected the following areas:

- ward 1
- ward 2
- ward 3
- ward 4, and
- ward 5.

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with patients, such as during patient mealtimes
- spoke with patients, visitors and ward staff, and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Forth Valley to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On Wednesday 24 September 2025, we held a virtual discussion session with key members of NHS Forth Valley staff to discuss the evidence provided and the findings of the inspection.

As part of our inspection process, we also requested to meet with senior managers within NHS Forth Valley on 10 and 24 October to highlight concerns. The purpose of the meetings was to seek further clarity and additional information regarding the content of some patient safety electronic incident reports. These reports detail patient safety incidents reported by staff in the three months prior to the inspection. Our concerns relate to a number of adult support and protection issues and incidents of patients absconding or managing to get on to the garden roof space including at times when on continuous observations.

We will continue to seek assurance in regard to the serious concerns raised at future inspections and through NHS Forth Valley's improvement action plan.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Forth Valley, and particularly all staff at the Mental Health Unit in Forth Valley Royal Hospital for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection'.

During the inspection, we observed staff treating patients with care and compassion.

Inspectors observed delivery of care in line with the evidence-based stress and distress model for reducing distressed behaviours in people with dementia.

Mealtimes were well organised with patients being offered a choice of meals.

NHS Forth Valley have a programme of activities specifically designed to improve the physical health of patients throughout the Mental Health Unit.

Patient information was available in a variety of formats including electronically to ensure accessible.

However, areas for improvement identified include ligature assessments that were inconsistently completed and did not align with the NHS Forth Valley ligature risk assessment policy. The healthcare environment was variable with some areas in a poor state of repair.

Improvements are required in the oversight of patient and staff safety incidents, including delays in reviews of adverse events. Themes within patient safety incidents reported by staff in the three months prior to the inspection, include several adult support and protection issues and incidents of patients absconding and managing to get on to the garden roof space.

We observed the impact of low staffing levels on staff training and supervision with low rates of basic life support training and child protection training.

As a result of concerns identified during inspection that required immediate improvement, we wrote to NHS Forth Valley Executive Team on two occasions. On the first occasion to raise concerns regarding adult support and protection, patient safety and governance and assurance and oversight of the Mental Health Unit in Forth Valley Royal Hospital. In response, NHS Forth Valley provided additional assurance of immediate and planned improvement actions taken to address these concerns. Information included in the response is detailed throughout Domain 1.

On the second occasion, to seek assurance on improvement actions related to staff training rates and patient dignity and respect within the adult mixed sex wards. However, NHS Forth Valley could provide only limited assurance of improvement in staff training and of the mitigations put in place to preserve patient dignity and respect within mixed sex areas. The physical environment, within some ward areas,

does not support full mitigation of these risks. We have also shared these concerns with the Mental Welfare Commission.

Other areas for improvement identified include ensuring policies and procedures were up to date and compliance and completion of audits.

What action we expect the NHS board to take after our inspection

This inspection resulted in eight areas of good practice, one recommendation and 19 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Forth Valley to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.scot

Areas of good practice

Domain 2	
1	Inspectors observed staff debriefs happening after an incident within the unit (see page 28).

Domain 4.1	
2	Staff were working hard to deliver compassionate care (see page 31).
3	Ward areas were calm and well organised (see page 31).
4	Patient information was available in a variety of formats including electronically to ensure accessibility (see page 31).
5	Mealtimes were well organised with patients being offered a choice of meals (see page 31).

Domain 6	
6	Inspectors observed respectful interactions between patients and staff (see page 38).
7	NHS Forth Valley have a programme of activities specifically designed to improve the physical health of patients throughout the unit (see page 38).
8	Community meetings are held to allow patients to provide feedback and contribute to their care (see page 38).

Recommendation

Domain 2	
1	NHS Forth Valley should consider the benefit of extending access to reflective session to staff in older adult wards within the Mental Health Unit (see page 28).

Requirements

Domain 1	
1	NHS Forth Valley must ensure safe and effective policies and procedures are in place for all CCTV cameras in use. CCTV cameras must be operated in line with national regulation, guidance and local policy and staff are aware of and apply correct procedures (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 2.7
2	NHS Forth Valley must ensure effective governance and oversight of all necessary staff training to support all staff to safely carry out their roles. This includes, but is not limited to, basic life support, public protection, prevention and management of violence and aggression training and training in relation to specialist admissions (see page 24). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 Criteria 12II & Core Mental Health Standards (2023) Criteria 2.3 & 4.1 and relevant codes of practice of regulated healthcare professions.
3	NHS Forth Valley must demonstrate how it supports the ongoing development of skills and knowledge through adequate supervision and appraisal for staff (see page 24). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 Criteria 12II & Core Mental Health Standards (2023) Criteria 2.3 & 4.1 and relevant codes of practice of regulated healthcare professions.
4	NHS Forth Valley must ensure processes are in place to continue to mitigate the risk of access to the roof in the outdoor space and monitor the impact of any interventions in place (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 5.19
5	NHS Forth Valley must ensure improvement actions are complied with and progressed with agreed timescales to reduce ligature risk identified through significant adverse event reviews and HSE improvement notices (see page 24).

	This will support compliance with: Health and Social Care Standards (2017) Criteria 5.18 & 5.19
6	NHS Forth Valley must ensure effective oversight of ligature risk assessments and any identified risks to ensure these are effectively mitigated (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 5.19 & 4.19 and Quality Assurance Framework (2022) Indicator 2.6 and 4.1
7	NHS Forth Valley must ensure management processes to identify ongoing risk and ensure timely review, oversight and implementation of adverse event improvement actions align with The National Framework for Reviewing and Learning from Adverse Events (2025) (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.24 & 4.19 and The National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (2025)
8	NHS Forth Valley must ensure systems and processes are in place that support the effective identification and mitigation of risk to ensure a safe environment for all patients (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.24, 3.20, 4.1 & 5.19
9	NHS Forth Valley must ensure fire safety doors are maintained in a safe working order that enables safe fire evacuation and reduces the restriction of movement around the older adult wards (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.1 & 5.19 & The Fire Safety (Scotland) Regulations 2006
10	NHS Forth Valley must ensure effective and appropriate governance approval and oversight of policies and procedures that are in place (see page 24). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.24 & Quality Assurance Framework Criteria 2.6

Domain 2	
11	NHS Forth Valley must ensure that there are clear assurance processes and systems, and these are planned and organised in a way that provides assurance that high quality care is being delivered (see page 28). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.11 & 4.19
12	NHS Forth Valley must ensure there is oversight and consistent application of screening tools to identify the risk of falls or pressure sores across all wards in the Mental Health Unit (see page 28).

	This will support compliance with: Health and Social Care Standards (2017) criteria 1.14 & 4.11

Domain 4.1	
13	NHS Forth Valley must ensure the care environment is in a good state of repair to support effective cleaning and that effective assurance systems are in place to support the reporting of environmental issues and the monitoring of the care environment (see page 31). This will support compliance with: National Infection Prevention and Control Manual (2023), Infection Prevention and Control Standards (2022), Healthcare Associated Infection (HAI) standards (2015) Criterion 8.1 and Health and Social Care Standards (2017) Criteria 5.19 & 5.24
14	NHS Forth Valley must ensure consistent recording of flushing of infrequently used water outlets to improve compliance and provide assurance in line with current national guidance (see page 31). This will support compliance with: National Infection Prevention and Control Manual (2023)

Domain 4.3	
15	NHS Forth Valley must ensure there are clear and consistent systems and processes in place for the monitoring and mitigation of any severe and/or recurring staffing risk to support longer term workforce planning (see page 35). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019
16	NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support and monitor wider system oversight, of identified staffing or safety risks within the Mental Health Unit (see page 35). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019
17	NHS Forth Valley must demonstrate how it supports, monitors and reviews the provision of adequate time to lead and resources available to clinical leaders (see page 35). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019

Domain 6	
18	NHS Forth Valley must ensure meaningful activity is consistently provided, including weekends, and that activity plans are completed and updated (see page 38). This will support compliance with: Quality Assurance Framework (2022) Criteria 2.2 & Health and Social Care Standards (2017) Criteria 2.21 and 2.22
19	NHS Forth Valley must ensure that patient's privacy and dignity is maintained, adult support and protection issues are assessed at all times including having appropriate toilet and showering facilities that support dignity and privacy in a mixed sex environment (see page 38). This will support compliance with: Health and Social Care Standards (2017) Criteria 5.1

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

We raised concerns with senior managers regarding patient safety and adult support and protection. Additionally, compliance rates with staff mandatory training are low and require improvement.

The Mental Health Unit at Forth Valley Royal Hospital has five mixed sex wards with a total of 89 beds that provide inpatient services for people with mental illness. Ward 1 is an Intensive Psychiatric Care Unit (IPCU), wards 2 and 3 are general adult admission wards, ward 4 is a dementia specialist ward and ward 5 is an admission ward for older adults. Ward 2 provides adult mental health beds for the Clackmannanshire and Stirling area and ward 3 for the Falkirk area. Both older adult wards cover the Forth Valley area. Referrals for admission are through the Mental Health Acute Assessment and Treatment Service. However, admission to the Intensive Psychiatric Care Unit can be through the criminal justice system, the forensic community mental health service and direct referral from outpatients and other mental health wards within NHS Forth Valley.

At the time of inspection, the overall capacity of the wards within the Mental Health Unit was 85.2%. Meaning there were beds available for admission and there was no waiting list for the unit.

An Intensive Psychiatric Care Unit is a locked ward for patients who are in an acute phase of serious mental disorder. There were two additional “surge” beds available in the Intensive Psychiatric Care Unit. These are temporary hospital beds that are added to increase capacity during periods of high demand and are in addition to the funded establishment, within the unit. However, these were not being used at the time of the onsite inspection. The surge beds were in established bed spaces previously used as patient rooms with access to toilet and shower facilities.

Through evidence reviewed we observed that the surge beds had been in use on several occasions within the three months prior to the inspection. We were told by senior managers that the beds are for those who require admission to the Intensive Psychiatric Care Unit and therefore the same criteria and threshold for admission applies. They told us that the decision to use the surge beds is made collaboratively by the clinical nurse manager and consultant. Where the need to utilise surge beds occurs senior managers will review staffing requirements in line with patient acuity to ensure safe staffing and if there is a requirement for additional staffing, staff can be sourced from the nurse bank or through redeploying staff from the other mental health wards within NHS Forth Valley.

The adult acute admission wards have provision for specialist admissions including detoxification from alcohol, perinatal, child and adolescent mental health and for treatment of an eating disorder.

In evidence submitted, we observed guidelines for the planned admission of patients undergoing alcohol detoxification. Care is coordinated through weekly planning meetings between inpatient and substance use services staff and is overseen by the liaison consultant psychiatrist. Training and support are provided by the hospital addiction team. There is also a planned inpatient assisted alcohol withdrawal pathway which is currently awaiting update as it was due for review in March 2024. We were told this delay was due to awaiting the publication of national guidance.

Admission to the Forth Valley Royal Hospital Mental Health Unit with an eating disorder is infrequent with only three admissions in five years. Admission to the Mental Health Unit is only considered if a bed in the regional eating disorder unit is not available and criteria for admission to an acute medical ward is not met. In evidence provided we observed that care is jointly managed by the eating disorder consultant and the inpatient consultant with support from the Mental Health Unit dietician.

NHS Forth Valley does not have a specialist inpatient mental health ward for children and young people. This means that young people aged 16 or 17 requiring admission to a specialist inpatient Mental Health Unit could be temporarily cared for in the ward 3 annex. This annex has provision for one ensuite bedroom for a young person under the care of Child and Adolescent Mental Health Services (CAMHS) and is utilised if an inpatient bed is not immediately available within regional Child and Adolescent Mental Health Services (CAMHS).

The Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice states that a child or young person should only be admitted to an adult ward in exceptional circumstances, for example, where no bed in a child or adolescent ward is immediately or directly available. This is because of the child or young person's vulnerability and the potential impact of an adult environment on the child or young person's mental health. Ward 3 annex also has a mental health perinatal bed. The pathway for admission into these beds all had distinct oversight arrangements and referral criteria.

During our onsite inspection there were no patients aged 16-17 being cared for in this area. However, we were provided with evidence of four admissions of patients aged 16 to 17 in the six months prior to inspection. Best practice guidelines state that hospital managers should advise the Mental Welfare Commission when a young person is admitted to a non-specialist adult ward. Senior managers informed us that these guidelines are followed, and the Mental Welfare Commission were informed following each admission.

Where a patient aged 16 or 17 is admitted to ward 3, their care is planned and overseen by the CAMHS Consultant Psychiatrist and the Intensive Child and Adolescent Mental Health Nursing Team, who attend the ward daily on weekdays.

Senior managers told us that care of the young person is led by ward 3 staff at the weekend in line with the planned care and reviewed by the consultant if necessary. Patients under the age of 18 are also placed on continuous intervention to mitigate the risk within the adult environment. Patients under 16 are admitted to the paediatric ward with support from registered mental health nurses if required. In evidence provided we noted that the standard operating procedure for the intensive CAMHS nursing team is still in draft form with no target completion date.

Inspectors were also told by nursing staff that patients requiring mental health inpatient treatment in the perinatal period may be admitted to the annex in ward 3. The perinatal period spans from conception until the child is one year old. In most circumstances, women in the first postnatal year who require admission to a Mental Health Unit will be admitted to a regional unit where they can be cared for with their baby 24 hours a day. In evidence we observed that there has been one admission of a patient in the perinatal period in the past year. Staff told us that only the patient would be admitted to ward 3, their baby would not be admitted. Senior managers told us that a responsible adult such as a family member or friend would be required to be available when the baby is visiting as staff could not take responsibility for the care of the baby whilst on the unit. Staff also told us that CCTV is available and activated when a baby is in the unit. Staff told us that when a patient is admitted to this bed, signage would be put in place highlighting the use of CCTV in the ward when it is in use. Senior managers told us the CCTV is monitored by security staff in a centralised security office. Limited guidance to support the use of the CCTV in this area is documented within the NHS Forth Valley Inpatient Perinatal Protocol. However, the document is overdue for review from 2023 and the information within the document is limited. NHS Forth Valley could not provide a dedicated CCTV policy, operating procedure or the risk assessment for the use of the CCTV. A requirement has been given to support improvement in this area.

The admission and care of a patient in the perinatal period is planned and overseen by the Perinatal Consultant Psychiatrist and the Perinatal Mental Health Team, who are based in the Mental Health Unit and attend daily on weekdays. Senior managers told us that care of the patient in the perinatal period is led by ward 3 staff at the weekend in line with the planned care and reviewed by the consultant if necessary.

We spoke with senior managers about the challenges in maintaining the knowledge and skills of staff when admission of specialist patients is infrequent. We were provided with evidence of training and support for staff regarding the specialist admissions to the Mental Health Unit. This included training rates on perinatal and child and adolescent mental health eLearning. Within evidence provided only 3% of staff had completed these.

We raised concerns regarding training compliance rates, with senior managers who provided a phased plan of completion of both the essential perinatal and essential CAMHS modules for ward 3 staff with a target completion of 90% by March 2026. In

response to the concerns we raised regarding staff training, we were informed 17% of staff within ward 3 had completed the training following the onsite inspection.

Compliance with child support and protection training was also low. Although senior managers provided an update that 80% of staff have completed public protection eLearning as mandatory training, which includes child protection, specific child support and protection training is not currently required. We noted in evidence that no staff had completed child protection awareness for clinical staff and only two members of staff within the Mental Health Unit had completed child protection for the general workforce.

In response to this, senior managers told us that all ward 3 staff will complete child protection awareness for clinical staff training with further consideration given to embedding additional child protection training as mandatory for all staff within the Mental Health Unit.

Other mandatory training includes basic life support, public protection, fire safety and violence and aggression training. From information provided, compliance across the unit was variable with 75% of staff having completed eLearning in both fire safety and violence and aggression and 60% of staff having completed the practical element of prevention and management of violence and aggression. Recognition of the deteriorating patient during restraint is part of the management of violence and aggression training completed by staff. However, only 21% of staff who work in the Mental Health Unit have completed the eLearning module introduction to adult resuscitation and only 10% have completed the accompanying face to face training. Basic life support training is essential for maintaining a safe and effective healthcare environment and allows staff to act quickly and confidently in critical situations.

In evidence provided we noted that low compliance with mandatory training was discussed at the NHS Forth Valley mental health and learning disability clinical governance working group in July 2025, highlighting current staffing challenges impacting on compliance rates. The impact of staffing shortages and increased acuity on access to training is demonstrated throughout the evidence provided by NHS Forth Valley.

Senior managers told us that they have several strategies to support improved compliance including work to identify protected time for staff on the wards and a phased approach to increasing compliance. The initial focus is on five key priority areas for training to improve compliance. The five priority training areas are infection and prevention control, public protection, violence and aggression, moving and handling and fire safety.

However, basic life support is not included within the top five key priority areas. This is essential to ensure staff have the skills and knowledge to identify and care for the medically deteriorating patient. We raised this with senior managers who, in response, have added basic life support as a priority training area and additional training and support is being offered to ensure staff can safely manage medical emergencies.

Several staff within the unit have been prioritised for basic life support training places in November and December 2025. Additionally, four registered nurses within the unit have been identified as trainers and will deliver training under supervision from NHS Forth Valley resuscitation team until they are confident enough to lead independently. Since 2018 senior charge nurses within the ward have also undertaken simulation training to increase the delivery of this training which includes managing medical emergencies in the psychiatric setting. However, only 14% of staff have completed this training. There have been no staff trained in 2025 due to the unavailability of trainers. Senior managers anticipate that this will recommence from March 2026 when senior charge nurses have completed simulation faculty training.

Whilst we acknowledge NHS Forth Valley's plans in place to address staff training requirements, we remain concerned at the very low levels of training compliance. This concern was included within our letters to senior managers at NHS Forth Valley. NHS Forth Valley must ensure that staff have the opportunity to access training relevant to their role, with effective governance and oversight processes in place to monitor training compliance to ensure staff can maintain the knowledge and skills required to provide safe and effective care. A requirement has been given to support ongoing improvement in this area.

On one ward staff told inspectors that due to low staffing levels they were unable to attend line management supervision, and that annual staff appraisals were overdue. The personal development planning and appraisal process provides a framework for managers to give feedback and support to staff resulting in a more positive work culture. In evidence provided we noted that only 34% of staff across the Mental Health Unit had completed their appraisal. We asked how staff can be supported to maintain skills and knowledge where appraisals are not being completed which may highlight support or training needs. Senior managers told us that appraisal, and the development of personal development plans were a priority for the senior leadership team and work was underway to improve recording of this as well as compliance. A requirement has been given to support improvement in this area.

We asked for details of all patient and staff safety incidents reported in the three months prior to our inspection. There were 516 incidents reported through the electronic incident reporting system across the areas inspected with the majority of incidents categorised as aggressive, violent or challenging behaviour. Inspection findings relating to reported patient safety incidents will be discussed throughout the report.

During our onsite inspection we observed several patients being cared for under continuous intervention supported by staff. Continuous intervention ensures close monitoring and therapeutic engagement with someone who needs intensive support to reduce the risk of harm to themselves or others. Decisions to initiate continuous intervention are based on the risk to the individual and others and should be the least restrictive intervention that maintains safety and promotes recovery in line with the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003. Inspectors

observed ongoing interaction with patients during the inspection. In evidence we were provided with the therapeutic engagement policy and noted that 72% of staff have received training in therapeutic engagement. We were given further evidence that NHS Forth Valley will continue to monitor and report on the completion of therapeutic engagement training. During the inspection we observed that the patients being cared for on continuous intervention had plans in place and patient interaction records were complete and up to date in line with the NHS Forth Valley therapeutic engagement policy.

However, within patient safety incidents reported by staff from the three months prior to the inspection, we observed several incidents of patients absconding while being supported on continuous interventions. This included patients managing to get on to the garden roof space. Although we saw no evidence that patients had been harmed through accessing this roof area, it is a significant patient safety risk. We met with NHS Forth Valley senior managers and wrote to the board to raise serious concerns around patient safety issues including patients absconding via the roof whilst on continuous interventions. In response, NHS Forth Valley have provided detailed improvement plans to address these risks. These include risks and mitigations being communicated through nursing handovers and daily multi-disciplinary huddles to ensure team-wide awareness, shared learning and collective recognition of the need for consistent application of safety measures. Individual risk assessments for each ward have been completed and discussions held with the multi-disciplinary team. In addition to these risk assessments, the risk of patients accessing the roof has been escalated to the corporate risk register and will be subject to greater visibility and scrutiny. Further work includes exploring further risk management interventions in collaboration with NHS Forth Valley estates and facilities and health and safety teams. NHS Forth Valley must ensure processes are in place to continue to mitigate the risk and monitor the impact of any interventions in place to reduce this. A requirement has been given to support improvement in this area.

NHS Forth Valley have an ongoing programme of works in relation to the reduction of identified ligature risks throughout mental health services. A ligature point is a fixture or object in a room where a ligature can be secured. Annual ligature risk assessments are part of an ongoing programme of assurance within NHS Scotland to reduce the number of incidences of self-harm or suicide by identifying potential ligature points and ensuring the controls and mitigations are in place to reduce identified risks.

An incident in the Mental Health Unit in October 2024 resulted in a significant adverse event review and an improvement notice being issued by the Health and Safety Executive regarding ligature point safety in one ward. In response to this NHS Forth Valley produced an action plan for improvements focusing initially on areas identified as high risk within the wards inspected.

We were provided with evidence of a timeline for improvements in response to the Health and Safety Executive notice, including the replacement or amendments to

wardrobes within patients' bedrooms and windows and doors throughout the unit. Completion of the programme of replacement of windows and doors within the Mental Health Unit is estimated to be by January 2027. Senior managers told us that to mitigate the risk of potential ligature points on windows until completion of the work they have locked all the windows, and they are only open when staff are in the room with patients.

Work to amend or replace wardrobes to reduce ligature risk is ongoing with a prototype wardrobe installed in one bedroom in ward 3. Following consideration of this, amendments or replacement of all wardrobes throughout the unit will be confirmed. No timeframe had been identified for this at the time of inspection. A requirement has been given to support improvement in this area.

Senior managers told us that an online training module focusing on the identification of ligature risks is in the final stages of being amended for use with NHS Forth Valley staff. A new clinical mental health risk assessment has been sourced and is currently out for consultation within the clinical governance structures. Following this process an implementation plan will be developed which will commence in November 2025.

The online training module and clinical mental health risk assessment are both being implemented to support the improved identification and mitigation of risk in all wards across the Mental Health Unit. A target for the completion of staff training in ligature risk assessment has been set at 90% of staff trained by April 2026. We were provided with the current ligature risk assessments for all the mental health wards within the unit inspected. Senior managers told us that these were completed by a multidisciplinary team as outlined in the NHS Forth Valley ligature assessment and assurance policy. We observed that although the risk assessments scoring was complete there were inconsistencies in completion with comparable areas in wards being scored differently and current controls not always clear. Action plans were also not completed with progress reports and dates of completion. Within ward level risk registers we observed some controls were highlighted including the use of clinical risk assessments, hourly observation checks and anti-ligature fittings. However, there are inconsistencies with these and with the severity of outcome being assessed as different for each ward.

NHS Forth Valley's ligature assessment and assurance policy states scoring regarding the access to a ligature in mental health wards should always be considered at the highest level of risk and scored accordingly. This was not evident in the ligature risk assessments for any of the wards inspected. These discrepancies highlight that the oversight of ongoing ligature assessments may not provide sufficient assurance around the reduction and mitigation of ligature risks within the Mental Health Unit. A requirement has been given to support improvement in this area.

Staff we spoke with told us that they were concerned about the ongoing risk in relation to the anti-ligature safety beds currently in use throughout the Mental Health Unit. Staff told inspectors of two recent incidents related to the beds in relation to patient and staff safety. We were told of an incident in June 2025, where the patient had dismantled their bed and sustained an injury when climbing inside. Due to the risk of further injury, the bed was removed from the patient's room. Another type of bed was trialled however was subsequently deemed unsuitable. This resulted in a patient sleeping on a mattress on the floor, while other bed options were considered. Whilst we acknowledge the removal of the weighted bed was to support patient safety, we raised concerns with senior managers about the impact of the ongoing use of a mattress on the floor in relation to the patient's comfort and dignity. We asked for this to be addressed as a matter of urgency. Senior managers were able to confirm that a suitable bed was received and in use by early September 2025. Senior managers also confirmed a decision had been made to replace all the weighted beds due to risk of injury from the disassembled bedframe and two models of beds had been ordered and are being trialled in the Mental Health Unit to ensure these were suitable for the environment.

The use of seclusion within mental health inpatient areas should only be considered where there is a clear and identified risk that the patient presents a significant degree of danger to themselves or other people, and the situation cannot be managed more safely or appropriately by any other means. The Mental Welfare Commission suggests that all health boards should have a policy on the use of seclusion whether it's used or not. We asked about the use of seclusion and staff told us that an area within the Intensive Psychiatric Care Unit was being developed to be used for seclusion, however a timeframe for the work had not been agreed. Senior managers told us that there was currently a group working to develop seclusion guidance for NHS Forth Valley. In evidence, we were provided with the draft policy that includes the use of seclusion and long-term segregation. We spoke with senior managers who told us that the final draft has been agreed and will proceed to the mental health and learning disability clinical governance group for review and approval. They confirmed that this process is expected to be completed by February 2026. Within patient safety incident reports reviewed there were no reported incidents relating to seclusion being used.

Patient and staff safety incidents or near misses are recorded on an electronic reporting system and escalated in line with NHS Forth Valley’s guidance for management of adverse and significant events. The level of the review is then determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. The adverse events review group meet weekly and identify incidents which may require referral for Significant Adverse Events Review (SAER) or local management review. We were provided with several adverse event review brief initial review documents. These provide evidence of consideration of risk and potential learning and include issues identified by the families, arrangements for staff support and areas of good practice.

NHS Forth Valley have a local adverse events policy and adverse events guidance for staff within mental health services. The National Framework for Reviewing and Learning from Adverse Events (HIS 2025) is not yet used within NHS Forth Valley but senior managers told us that work is underway to implement this.

We were provided with evidence of incidents being reviewed by the NHS Forth Valley adverse event review group. We also saw in evidence a six-monthly adverse events learning newsletter which details common themes of incidents, outcomes and learning. Senior managers told us that this is cascaded to staff.

However, we observed that several reviews were not carried out or completed within the identified timescale target highlighted for completion. Some initial reviews were carried out up to nine months from the date of the incidents. Within The National Framework for Reviewing and Learning from Adverse Events completion of a level 1 significant adverse event should be completed within 140 days. NHS Forth Valley wide policy aligns with Healthcare Improvement Scotland National Framework timescales. Delays to adverse events reviews can delay systematic learning and improvement within the service and cause ongoing harm and trauma to patients, staff and families. NHS Forth Valley must ensure their current incident report management processes are sufficient to ensure timely review and effective oversight to identify and action any learning. A requirement has been given to support improvement in this area.

Within patient and staff safety incidents reports reviewed we identified two reported incidents of the pinpoint alarm system failing to work on activation. Pinpoint alarms are carried by all staff and are part of a system integrated into the ward environment to allow staff to respond promptly to any emergency situations. Both the alarm company and estates have reviewed the incidents and identified blind spots where the alarms do not activate. There are also additional limitations identified in relation to the infrared sensors when too many staff are involved in an incident. An email had been sent to all staff to highlight risks and mitigations with the pinpoint alarm system, and we were also told that information is shared through the safety brief for non-substantive staff. Additionally senior managers advised inspectors that they are working with the company who provide the alarms to identify and manage actions to reduce the risk of the system not working effectively. As part of this work, we observed evidence of a request in October 2025 to purchase and install additional sensors in the garden areas to ensure the alarms function efficiently in that area. We were provided with evidence that this risk had been escalated through the May inpatient digest for the Mental Health Unit. It was also added to the mental health risk register with initial mitigation of the highlighted risk being disseminated to teams across the mental health estate who currently use the alarm system. The mental health inpatient unit digest is a monthly summary document produced following the Mental Health Unit clinical governance and management group. The summary identifies themes, learning and challenges for discussion and escalation to the mental health and learning disability service clinical governance working group.

Within other patient safety incident reports, we were concerned about incidents regarding significant adult support and protection issues, including sexual safety. Senior managers provided evidence of a clinical risk assessment in place that identified concerns relating to vulnerability. However, there was no explicit prompt to consider sexual safety within the assessment. In our letter to NHS Forth Valley senior management team we raised our concerns and requested more information regarding the oversight of adult support and protection risks. Senior managers were able to provide evidence that requirements in relation to duty of candour had been met. This is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm. Further information on Duty of Candour can be found here.

During discussions senior managers told us that the mitigation of risk around sexual safety for patients was an ongoing challenge due to both the vulnerability of patients, sexual disinhibition and sexualised behaviours being a symptom that people may experience due to significant mental illness or dementia. We were given evidence of a clinical risk assessment used within the Mental Health Unit that identified concerns relating to patient vulnerability. However, this did not contain any explicit prompt to consider sexual safety within the assessment. Additionally, we were provided with further evidence of work to support safe disclosure of sexual harm and guidelines for staff to access the correct support for patients. Patients can be signposted to The Meadows which is a specialist sexual assault response coordination service based near Forth Valley Royal Hospital for those who have experienced trauma. However, we remain concerned that there was a lack of management ownership and oversight of patient safety, support and protection for patients cared for within the Mental Health Unit prior to concerns being raised through the inspection process.

Work around adult support and protection has led to the development of a draft NHS Forth Valley sexual safety policy and the implementation of a sexual safety champion to heighten awareness of risk. The policy will be fully implemented in March 2026. In further evidence provided following the letter of serious concern, senior managers provided us with a several measures to strengthen preventative intervention and awareness of sexual safety for all patients across NHS Forth Valley. These include the addition of an explicit prompt to consider sexual safety in the initial assessment for patients within the Mental Health Unit, a review of past incidents to identify learning and inform improvement work and a review of the current configuration of the wards within the Mental Health Unit. Additionally ongoing improvement work will be informed by the National Sexual Safety Collaborative (2020). These were commissioned by NHS England in 2020 and include standards and guidance to improve sexual safety in mental health and learning disability inpatient areas. We welcome improvement actions taken by NHS Forth Valley in response to concerns we have raised. However, we are not yet assured, that adequate systems and processes were in place prior to this inspection. NHS Forth Valley must ensure that the identification and mitigation of risk is sufficient to ensure a safe environment for all patients and this must include sexual safety. A requirement has been given in relation to this concern.

The Core Mental Health Standards were published in September 2023 and were developed to support individuals, their families and carers to understand what they can expect from mental health services and ensure a person-centred approach is central to the provision of care and treatment. Healthcare Improvement Scotland have collaborated with health boards to complete a baseline local self-assessment to support board areas to start to consider how well they currently implement each area of the standards within working age adult inpatient mental health services. NHS Forth Valley have identified priority areas for improvement and have convened a steering group to lead improvement in the areas highlighted. These include improving engagement with people with lived experience and collection and use of data around patients' outcomes and experiences. An electronic portal will be developed to monitor the progress of implementation.

On the first day of inspection, we observed that fire doors throughout the internal corridors of both older adult wards were in the closed position, and we observed patients with walking aids unable to open them. There was no signage regarding the door being push or pull. On the second day of the onsite inspection, maintenance was being carried out to ensure the fire doors could be kept open unless in the event of a fire. In evidence provided we noted that the fire risk assessments provided for both older adult wards highlighted that the fire doors require regular maintenance due to the locking mechanism. We were told that this is routinely reported to estates who arrange repairs. In evidence provided we observed that the doors are prioritised as urgent and therefore have been repaired on the same or next day after being reported. This has happened five times since January 2025. This also means that there are periods where access to the wider ward is restricted due to the doors being closed. NHS Forth Valley must ensure that the ward is a safe and accessible space for all patients. Senior managers told us that fire doors will be reviewed as part of the estate's lifecycle plan. A requirement has been given to support improvement in this area.

In evidence provided we observed that eight patients were experiencing delayed discharge, with five in the adult wards and three in the older adult areas at the time of inspection. Delayed discharge refers to situations where a patient, who is clinically ready to leave hospital, cannot do so because the necessary care, support, or accommodation is not available. This can occur for various reasons, such as waiting for care home placement, community care arrangements, or adaptations to a home environment. A delay to a patient’s discharge can have a detrimental effect on their wellbeing, such as a loss of confidence or independence. We raised this during our virtual discussion where senior managers explained that patients continue to receive input as outlined in their care plan and would continue to access groups and activities throughout their admission to the Mental Health Unit. They told us of ongoing work in relation to discharge planning with monthly multi-disciplinary meetings with representatives from social work and housing that focus on finding solutions for those who no longer require to be in hospital. In addition, there is work underway to align with acute services, and a dashboard approach is being considered to ensure

accessible accurate information and criteria for delayed discharge is collected and reported consistently across the board area.

Within the evidence provided several policies and procedures were overdue for review within NHS Forth Valley's governance process. These include Intensive Psychiatric Care Unit admission criteria as above, the perinatal inpatient protocol and the alcohol withdrawal pathway which will be discussed later. NHS Forth Valley must ensure current draft and out of date policies and procedures are updated and relevant to the current context in which care is delivered. A requirement has been given to support improvement in this area.

Requirements

Domain 1	
1	NHS Forth Valley must ensure safe and effective policies and procedures are in place for all CCTV cameras in use. CCTV cameras must be operated in line with national regulation, guidance and local policy and staff are aware of and apply correct procedures.
2	NHS Forth Valley must ensure effective governance and oversight of all necessary staff training to support all staff to safely carry out their roles. This includes, but is not limited to, basic life support, public protection, prevention and management of violence and aggression training and training in relation to specialist admissions.
3	NHS Forth Valley must demonstrate how it supports the ongoing development of skills and knowledge through adequate supervision and appraisal for staff.
4	NHS Forth Valley must ensure processes are in place to continue to mitigate the risk of access to the roof in the outdoor space and monitor the impact of any interventions in place.
5	NHS Forth Valley must ensure improvement actions are complied with and progressed with agreed timescales to reduce ligature risk identified through significant adverse event reviews and HSE improvement notices.
6	NHS Forth Valley must ensure effective oversight of ligature risk assessments and any identified risks to ensure these are effectively mitigated.
7	NHS Forth Valley must ensure management processes to identify ongoing risk and ensure timely review, oversight and implementation of adverse event improvement actions align with The National Framework for Reviewing and Learning from Adverse Events (2025).
8	NHS Forth Valley must ensure systems and processes are in place that support the effective identification and mitigation of risk to ensure a safe environment for all patients.
9	NHS Forth Valley must ensure fire safety doors are maintained in a safe working order that enables safe fire evacuation and reduces the restriction of movement around the older adult wards.
10	NHS Forth Valley must ensure effective and appropriate governance approval and oversight of policies and procedures that are in place.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

Staff in the majority of wards inspected told us of good teamwork, sufficient support and open communication within the team and at senior management level. We heard from staff that the use of debriefs following incidents are useful to identify learning and areas for improvement. Compliance with NHS Forth Valley audit schedule was variable.

NHS Forth Valley provided information describing the clinical governance structures in place. NHS Forth Valley has three board level Assurance Committees. These are the Clinical Governance, Staff Governance, and Performance & Resources committees which report quarterly to the NHS Board. Each committee has a distinct remit: the Clinical Governance Committee focuses on clinical risks and quality of care, including issues such as bed pressures and patient safety; the Staff Governance Committee oversees workforce-related risks, including staffing levels and training compliance; and the Performance & Resources Committee monitors service performance, including access and wait times.

Ward level governance and oversight of the Mental Health Unit is delivered through the Mental Health Unit clinical governance meeting and is summarised in the monthly service digest. As described in Domain 1, we were given a copy of the monthly digest for the Mental Health Unit for May 2025. We noted that data on falls, NEWS compliance, staffing and themes around incidents were reported through the monthly digest.

However senior managers told us that the unit clinical governance meeting had not happened for two months prior to the inspection due to workload and staffing issues. This may impact on effective governance and assurance.

Information provided in evidence identified that compliance and completion of audits at ward level was variable. We observed that in May and June 2025 some audits had incomplete submissions with gaps highlighted in the completion of infection control, falls and pressure care audits.

Care plans reviewed by inspectors during the onsite inspection were complete and up to date. However, within information provided the mental health care planning audit in one ward resulted in only 50% compliance. Gaps in assurance processes and low compliance rates may result in a lack of assurance that best practice guidance and standards are being met to support safe delivery of care.

The inspection team found challenges in ensuring sufficient assurance and oversight of audit systems due to the different methods of collating and reporting data. The evidence provided show some of this data being escalated through the clinical governance structure and some being captured in the quarterly care assurance visit reports. Senior managers told us work was underway to streamline reporting as part of the wider safer together collaborative work discussed in Domain 4.1. A requirement

has been given to support improvement in the completion, compliance and oversight of audit and assurance within the Mental Health Unit.

Staff in the majority of wards inspected told us of good teamwork, sufficient support and open communication within the team and at senior management level. However, in one ward we were told that communication to staff was poor, and they did not feel supported by clinical managers. We raised this with senior managers who told us of ongoing work to support the staff within the ward. Through evidence provided, we observed this was the ward that has reported an increase in patient acuity and incidences of violence and aggression in the six months prior to inspection which was impacting on staff morale. Senior managers told us a member of ward staff has now undertaken the train the trainer course for violence and aggression and will support the staff to build confidence in recognising triggers for violence and de-escalation skills. We also observed in evidence that a new senior charge nurse and deputy charge nurse were also in post and had a focus on reintroducing staff meetings and building relationships within the multi-disciplinary team to support staff wellbeing.

Staff within the adult wards in the Mental Health Unit also had the opportunity to attend monthly reflective practice sessions with the psychology team and lead nurse. Senior managers told us that uptake was good with up to six members of staff attending each session. The frequency was increased if there are increased challenges on the wards. During inspection staff also told us that when they had time to attend, it was valuable. In evidence provided we observed very positive feedback from staff who attended the sessions. However, we observed that the sessions were only available to staff in the adult wards. This means that staff who work in the older adult wards do not have the opportunity to attend. A recommendation has been made to support increased access to the sessions.

In one ward we were given evidence of a debrief template for both staff and patients following incidents such as violence and aggression where restraint was used. Conducting a post-incident debrief helps identify and address any harm to patients or staff, ongoing risks, and the emotional impact on patients and staff. It also identifies what was helpful and any learning points highlighted by staff and patients. Staff told us it would not always be appropriate to carry out a debrief with a patient immediately after an incident and this would be carried out at a suitable time to meet the patients' needs. Staff debriefs allow ward level discussion on incidents in relation to what went well and any areas for improvement. During the inspection we observed a staff debrief happening following an incident. This is good practice.

Inspectors observed an inconsistent approach to the assessment of patients who may be at risk of a fall or pressure area damage across the Mental Health Unit. We observed falls care plans in place in older adult wards. However, staff we spoke with in adult wards described using professional judgement to assess the need to complete pressure care or falls risk assessments. As discussed earlier in this report within incident reports reviewed falls were among the highest reported incidents. Within this

information, in only one incident a post falls review was completed, and a falls bundle was recommended in feedback following review of several incidents.

In relation to pressure area care, the lack of initial assessment in the adult wards is not in line with the NHS Forth Valley pressure ulcer policy for prevention, assessment and management that states that every patient admitted to Forth Valley Royal Hospital should have a formal pressure area risk assessment.

We raised the lack of initial falls and pressure area assessments in adult wards with senior managers who told us that concerns around physical health or frailty in relation to increased risk of falls or pressure damage would be highlighted in the initial physical health assessment on admission. However, as risk of falls or pressure damage are not explicitly highlighted within the physical health assessment patients who are at risk may not be identified.

In incident reports reviewed we identified one incident in which a patient who had been recently transferred from another NHS Forth Valley hospital had pressure damage. This was identified during personal care several days after admission. However, no pressure area risk assessment had been carried out for the patient on admission to the ward in the Mental Health Unit despite information within the handover that this was an ongoing care need. We noted it took one week from admission for an initial physical assessment to take place. Following review, the patient was given increased pain relief and referred to the tissue viability nursing service. We raised our concern with senior managers about the delay in identifying and assessing the pressure damage and the implementation of a care plan to ensure sufficient pain relief and treatment. They provided assurance they had already taken action, following submission of the staff member recording the incident report. The patients care had been reviewed and described a plan for increased scrutiny to ensure risk assessments are undertaken for all older adults being admitted to the Mental Health Unit on admission. We were provided with a new prevention pressure area policy which has been developed, and senior managers explained the implementation of this policy will be supported by the practice development team. We remain concerned about the lack of oversight of patient care, and effective risk assessment in place, to ensure patients at risk of falls or pressure damage within the adult wards in the Mental Health Unit are being identified on admission. A requirement has been given to support improvement in this area.

NHS Forth Valley provided a programme of induction which includes the Registered Mental Health Nurse Induction and preceptorship passport. This is a comprehensive document that details completion of mandatory and role specific training and ongoing competency and skills attainment. The demonstration of competency and the completion of evidence is signed off by a designated preceptor. Staff told us these are useful tools to ensure new staff are inducted to the service safely.

Area of good practice

Domain 2	
1	Inspectors observed staff debriefs happening after an incident within the unit.

Recommendation

Domain 2	
1	NHS Forth Valley should consider the benefit of extending access to reflective session to staff in older adult wards within the Mental Health Unit.

Requirements

Domain 2	
11	NHS Forth Valley must ensure that there are clear assurance processes and systems, and these are planned and organised in a way that provides assurance that high quality care is being delivered.
12	NHS Forth Valley must ensure there is oversight and consistent application of screening tools to identify the risk of falls or pressure sores across all wards in the Mental Health Unit.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

We observed warm and caring interactions with patients with evidence-based interventions being carried out. However, the healthcare environment, within several areas was in poor condition and in need of repair to ensure a safe and clean environment.

All wards inspected, although busy, were calm and organised throughout the inspection. NHS Forth Valley uses electronic care documentation. The majority of documentation that inspectors were able to review demonstrated a person-centred approach to care and was up to date. We observed evidence of patient and carer involvement and when patients were not involved the reason for this was documented.

We observed staff treating patients with care and compassion, showing dignity and respect and communicating clearly and sensitively. Inspectors spoke with patients who were mainly positive about the care they received.

Within the older adult wards, inspectors observed that care and comfort rounds were up to date and complete. Care and comfort rounds are a structured process that involves checks to address issues and identify care needs proactively. In the adult wards hourly improving observational practice (IOP) charts were completed which identify the whereabouts of all patients and encouraged brief interaction to allow opportunity for early recognition of deteriorating patients using a traffic light system

outlined in the therapeutic engagement policy. In evidence provided we observed that the hourly checks were able to identify risk and facilitate interventions to reduce or prevent harm.

NEWS2 charts were completed as prescribed and in one ward a board identifying the frequency of physical observations for each patient was displayed in the staff office. NEWS2 charts are used to record a patient's physiological parameters such as pulse and blood pressure and will alert staff if a patient is at risk of deterioration. We noted in evidence that in June 2025 compliance with the weekly NEWS2 audit was around 90% following a sustained improvement over the preceding year.

The safer together collaborative provides a framework for improvement designed to promote safe, reliable healthcare across NHS Forth Valley. Within the Mental Health Unit, we saw evidence of work to improve therapeutic activity with several wards having a full timetable of activity. This work is ongoing and part of a wider range of initiatives across mental health and learning disability services. The aim within the Mental Health Unit is to reduce incidents of violence and aggression by up to 30% with the increase of therapeutic activity across the unit. Additionally, evidence provided showed that although falls and violence and aggression were among the highest reported incidents, a reduction in falls throughout the unit was in line with the increase in therapeutic activity. Inspectors observed that in one area information relating to the outcomes were displayed and showed a reduction in incidents of violence and aggression. However, inspectors observed that activities in one ward were limited during the inspection. This is discussed further in Domain 6.

The Mental Health (Care and Treatment) (Scotland) Act 2003 emphasises patient rights, participation in decision-making, and person-centred care. Inspectors could identify legal status clearly.

Patient information was available within wards. Some used QR codes to provide patients with ward information and self-help resources for dealing with mental health concerns. The Mental Health (Care and Treatment) Act 2003 also highlights that every person with a mental illness should have the right to access independent advocacy services. Information on accessing advocacy services was readily available throughout the unit. Mental health advocacy provides independent support for individuals with mental health needs.

Inspectors observed a dementia friendly environment in ward 4 which provides specialist care and treatment for those with the condition. A dementia-friendly environment is designed to support individuals with dementia by minimizing confusion and enhancing their ability to navigate and function within their surroundings with clear signage on rooms and work done to improve the sitting room and therapy room. However, as discussed earlier in Domain 1 a requirement has also been given in relation to maintaining the fire doors to ensure access to the wider ward is not restricted.

Mealtimes were well organised, and a choice of food was offered. Many patients attended the dining room, but some patients elected to stay in their rooms. We saw that the staff on the ward went round each room and checked each patient to ensure they were attended to.

During the inspection patient care equipment was clean and ready for use. Storerooms were tidy and well organised. The hospital environment appeared clean. However, we observed evidence of considerable wear and tear throughout the Mental Health Unit, for example torn flooring in main ward corridor areas which was covered in tape, and peeling and damaged ensuite walls and floors. Damage to healthcare environments can impact effective cleaning and create a risk that a patient or member of staff could be injured.

In one patient bedroom that was not in use, we observed significant damage to the ensuite shower area. The wall was damaged with the covering peeled off and black marking over the shower wall. We raised our concerns with the senior managers immediately and requested evidence that this was actioned as a matter of urgency. The update by senior managers provided assurance that the work had been completed and the room was suitable for use.

Staff we spoke with told inspectors of the process of identifying repairs to estates. Forth Valley Royal Hospital is a private finance initiative building and is therefore maintained by a private maintenance contractor. Staff contact a helpdesk to request repairs and the responsibility for ensuring that issues are reported and followed up lies primarily with the Senior Charge Nurse. However, there is currently no formal oversight at ward level to ensure that all repair jobs have been logged, reported, or completed. Senior managers told us that reliance on individual diligence can lead to inconsistencies in tracking and resolution. Staff also told us that although urgent requests are mainly actioned timeously, those prioritised as less than urgent are often delayed. A requirement has been given to support improvement in this area.

Standard infection control precautions such as linen, waste and sharps management minimise the risk of cross infection and must be consistently practiced by all staff. Patients personal clothing was laundered on site and all other linen was processed at the hospital laundry. We observed both linen and waste were managed in line with the national infection prevention and control manual. Sharps boxes were all closed and marked with dates and names and not over filled. Alcohol based rub was available in locked areas of the wards due to risk to patients, and staff were seen using this appropriately.

Inspectors spoke with domestic staff who told us that they are able to complete their duties within their shift time and have sufficient access to supplies to clean their clinical areas. They also told inspectors they felt supported by their supervisor and were happy to raise any concerns to the supervisor or nursing staff. If they are unable to access a patient room this is escalated directly to the nursing team.

Wards inspected had infrequently used water outlets that require to be flushed twice weekly. In one ward nursing staff are required to do this on a Tuesday and Thursday and there was a process in place to record this. However, this was not consistent across the wards and we noted in one ward that staff were unsure who was responsible for this. We raised this with managers who provided assurance that a review of infrequently used outlets had been completed and any identified will be flushed twice weekly by staff and recorded appropriately. This will be monitored as part of the senior charge nurse monthly check. A requirement has been given to support ongoing improvement in this area.

Areas of good practice

Domain 4.1	
2	Staff were working hard to deliver compassionate care.
3	Ward areas were calm and well organised.
4	Patient information was available in a variety of formats including electronically to ensure accessibility.
5	Mealtimes were well organised with patients being offered a choice of meals.

Requirements

Domain 4.1	
13	NHS Forth Valley must ensure the care environment is in a good state of repair to support effective cleaning and that effective assurance systems are in place to support the reporting of environmental issues and the monitoring of the care environment.
14	NHS Forth Valley must ensure consistent recording of flushing of infrequently used water outlets to improve compliance and provide assurance in line with current national guidance.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Within the majority of wards, we observed good teamwork with most staff described feeling supported. However, staff raised concerns regarding the impact of ongoing staffing challenges on their ability to deliver safe and effective care.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that NHS boards have a duty to apply the Common Staffing Method (CSM), which includes a staffing level tool run and requires this to be applied rigorously and consistently. The application of the common staffing method and staffing level tool supports NHS boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high-quality care. As part of evidence, we observed staffing level tool runs had been undertaken in March 2025.

We were provided with the reports generated following the staffing tool run. This showed that patient acuity was considered high during the tool run period and recommended that the new mental health and learning disability tool is run in November 2025. Senior managers told us that additional training and support for staff in the use of this and the professional judgment tool and Safe Care will be rolled out from October 2025.

NHS Forth Valley use Safe Care to monitor real time staffing across the Mental Health Unit. Safe Care is an electronic staffing system which reports real time staffing requirements based on roster demand or patient care needs. This provides a traffic light system with red areas having the highest shortfall of staff available to meet patients' needs. This enables informed decisions to be made when deploying staff to help mitigate risk. This system considers the acuity of the patients versus available staffing numbers. It also allows for professional judgement to be made in terms of required staffing in relation to patient acuity.

Within evidence reviewed nursing staffing levels were consistently reported as amber using the RAGG (red, amber, grey and green) system within Safe Care. With green being optimal, amber the minimum safe staffing levels, and red indicating significant staffing shortages or skill mix. Inspectors onsite observed than when amber status was declared for all five inpatient ward areas, the outstanding bank shift requested for the upcoming shift were withdrawn meaning staffing levels would be unlikely to achieve green. Evidence reviewed demonstrated amber status for over 80% of the time for the last year. Staff we spoke with described staffing levels dropping down to red levels due to breaks or staff escorting patients off the ward for appointments or treatment. Inspectors observed staff moving between wards to provide cover for breaks, appointment or clinical incidents which required a temporary increase in staff numbers. While we recognise that this does not necessarily result in increased risk, NHS Forth Valley did not appear to have a formal process for the monitoring of this. A requirement has been given to support improvement in this area.

On one ward inspected staff we spoke with told us staffing levels often did not reflect the acuity of the ward. For example, the established staffing levels did not reflect the number of staff sometimes required to assist with personal care safely or to deal with incidents of violence and aggression. Staff throughout the unit also voiced concern regarding the ongoing staffing challenges and the impact of these on delivering care. As previously mentioned, some staff raised concerns regarding staffing numbers in relation to being able to attend training. However, staff we spoke with told us they are comfortable escalating any concerns with staffing and feel that they are generally supported by managers to do this.

There were five incidents in the three months prior to our inspection where staff reported low levels of staffing or inappropriate skill mix that mainly related to night shift. This led to delays in observational checks and staff getting breaks from the ward. We also observed that staff engagement and feedback provided in evidence highlighted areas where staff feel the low staffing levels have impacted on their ability

to deliver safe and effective care. In one ward staff said that timely completion of care documentation was a challenge although inspectors did not see evidence of this onsite. Attendance at supervision and protected time to attend training can be challenging due to clinical activity and staffing levels. In addition to this we observed in evidence that staff had highlighted difficulty accessing breaks in time. We noted that these incidents were all reviewed and staff were given a response to concerns through the incident reporting system.

We asked senior managers about the impact of low staffing and the use of Safe Care that confirmed consistent amber levels of staffing. They told us that although the Safe Care system has been in place for some time, they felt that assessment of safe staffing levels may not reflect the acuity in the wards. The introduction of a pilot of a dependency calculator in one ward in July 2025 is ongoing as part of work to review and realign categorisation of risk in relation to safe care. This is being supported by NHS Forth Valley staffing team.

Inspectors attended two Mental Health Unit site specific safety huddles and one wider service staffing huddle that included input from staff in Bellsdyke Hospital, Lochview and the mental health acute assessment and treatment service. Staffing requirements are reviewed at the huddles and actions are taken to mitigate risk such as movement of staff within the Mental Health Unit and from Bellsdyke hospital. Substantive staff, mainly healthcare support workers from NHS Forth Valley staff bank, are also utilised. We observed inclusive and open conversations with highlighted areas of concerns and risk regarding multi discipline staffing and acuity discussed with mitigations put in place where areas of concerns were highlighted. We observed actions taken to reduce staffing risks such as the movement of staff across the sites.

Senior managers also told us of a whole system call twice weekly that is attended by representatives from mental health services from throughout the board. The aim of the call is to assess the operational status across NHS Forth Valley enabling proactive management of any service pressures. However, there are no formal written note of outcomes or action.

Forth Valley Royal Hospital have an acute wide daily site huddle, however the Mental Health Unit was not represented at this. This is a potential missed opportunity to provide a daily wider system oversight of staffing and safety risks within the Mental Health Unit. Following our inspection senior managers provided confirmation that actions were being taken to improve the monitoring of attendance at site wide safety huddles and the recording of actions or issues raised during huddles. NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support and monitor wider system oversight of identified staffing or safety risks within the Mental Health Unit. This includes accurate recording of any escalation, mitigation/inability to mitigate and communication of outcomes with all relevant clinical teams. A requirement has been given to support improvement in this area.

Workforce data submitted by NHS Forth Valley for June 2025 demonstrates an overall nursing vacancy rate of 12.5% within the Mental Health Unit at Forth Valley Royal Hospital and a total sickness absence rate of 16.6%. We consider a high vacancy rate to be greater than 10% with the aim to achieve a sickness absence rate of 4% or less.

At ward level, senior charge nurses oversee daily staffing and deployment, to support skill mix across the Mental Health Unit. Clinical nurse managers monitor staffing trends, bank usage, and compliance with mandatory training. Concerns are escalated through operational governance structures to inform workforce planning and board-level oversight via the workforce governance group. However, as described earlier in this report, staff training compliance is significantly lower than expected, indicating that this system of monitoring has not been effective.

We asked senior managers how they manage workforce requirements considering the high sickness and vacancy rates within nursing staff. They told us that in relation to vacancies within the unit they are in the process of recruiting newly qualified nurses with 10 nurses accepting positions within the Mental Health Unit. Additionally, the process of recruiting health care support workers is underway with 13 whole time equivalent posts being sought. The current forecast will lead to over recruitment and may contribute to increased staffing throughout the Mental Health Unit in the longer term. We noted in Domain 2 that there is a comprehensive induction process for new staff.

We asked senior managers about the high 16.6% sickness absence rate and how staff are supported back to work after a period of sickness. In evidence submitted we observed that management of absence is led by the senior charge nurse with regular contact maintained with absent staff and oversight through managerial supervision with the clinical nurse manager. We also noted in evidence a trauma informed approach to staff support across NHS Forth Valley as part of their Workforce Wellbeing Plan which enables managers to be confident in supporting staff wellbeing. This is supported by a human resource advisor linked to the Mental Health Unit. Senior managers told us that they are currently undertaking a deep dive into sickness absence, and a vacancy panel has been established to address long term sickness and develop effective ways of supporting people back to work.

Time to lead is a legislative requirement under the Health Care Staffing (Scotland) Act (2019). This is to enable clinical leaders to provide the delivery of safe, high quality and person-centred healthcare. Staff in the wards told us that the senior charge nurses were regularly counted in numbers due to low staffing. In evidence provided we observed that ongoing pressures in managing ward demands and capacity continue to require both senior charge nurses and deputy charge nurses to work unplanned clinical hours to maintain safe staffing levels across all wards in the unit.

Time to lead is monitored by the clinical nurse manager and escalated through the workforce governance framework although we received no information about how often senior charge nurses are unable to fulfil managerial duties due to clinical acuity

and low staffing. NHS Forth Valley must ensure that senior nursing staff are given sufficient time to lead and this continues to be monitored and addressed. A requirement has been given to support improvement in this area.

Requirements

Domain 4.3	
15	NHS Forth Valley must ensure there are clear and consistent systems and processes in place for the monitoring and mitigation of any severe and/or recurring staffing risk to support longer term workforce planning.
16	NHS Forth Valley must ensure that there are clear, consistent systems and processes in place to support and monitor wider system oversight, of identified staffing or safety risks within the Mental Health Unit.
17	NHS Forth Valley must demonstrate how it supports, monitors and reviews the provision of adequate time to lead and resources available to clinical leaders.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

We observed patients treated with dignity and respect. Patients we spoke with were mainly positive about their experience. Information and feedback mechanisms for patients and carers were readily available throughout the Mental Health Unit. However shared toilet and bathroom facilities may impact on patients' privacy and dignity.

Inspectors observed that patients were treated with dignity and respect by staff. We observed warm and respectful interactions between patients and staff and person-centred interactions based on best practice models for dealing with distressed behaviour.

In one ward we observed a patient who was bare footed and in a hospital gown. Inspectors spoke with staff at the time of inspection who explained that this patient became very distressed when donning clothes. They told us of the challenges in maintaining dignity and implementation of a specific person-centred care plan to reduce distress but maintain dignity if the patient is unwilling or unable to get fully dressed. Inspectors observed that all other patients appeared clean and comfortable in their own clothes.

Stress and distress is an evidence-based approach for dealing with stressed and distressed behaviours that aims to improve the experience and outcomes of people living with dementia. Inspectors saw evidence that this approach, including the use of psychological formulation was used with patients in the older adult wards. The development of this had been supported by a psychology assistant assigned to work with patients in ward 4. However, nursing staff explained to inspectors that this resource was no longer available as the temporary post has come to an end. Staff

were concerned that the application of the stress and distress model would not continue due to staffing levels and insufficient numbers of staff being trained to support the approach. We observed in evidence that only six members of staff were trained in stress and distress at the time of inspection, including the senior charge nurse. This means that application of the model and in particular development of formulations in relation to stressed behaviour will be challenging. In further evidence provided we were given dates of further training and details of actions to support the ongoing implementation of the stress and distress model across inpatient and community services for those living with dementia. In ward 4 this includes weekly support from a clinical psychologist, increased capacity due to newly qualified nurse intake and identified periods of time dedicated to completion of the formulations.

We were given evidence of several quality improvement projects being undertaken. These included a project completed recently regarding the redesign of a sitting room for people with dementia in one ward. This incorporated reminiscence therapy, improved acoustics and softer lighting and colour palette. Evaluation of this showed a decrease in the number of falls and incidents of violence and aggression when compared to a comparable period prior to the introduction of the new sitting room.

Each ward within the Mental Health Unit had access to an enclosed outdoor area which appeared well maintained. As mentioned in Domain 1, the garden areas have identified risks around patients accessing the roof area. Senior managers told us they are working to mitigate this by employing environmental strategies such as limiting direct access from certain areas but also identifying if someone is at risk of absconding and requires additional support from staff.

People who experience significant mental health problems are at a considerably higher risk of developing physical health problems than the general population. Inspectors observed evidence of activities focused on improving physical health including body boost bingo in the older adult wards and a physiotherapy led programme of activities including boxing and gym access in the adult wards.

The provision of meaningful activity on mental health wards is said to increase social connectedness, improve psychological wellbeing and is essential to promote wellbeing and recovery. We observed evidence that activity coordinators, occupational therapy staff, nursing staff and physiotherapy are all involved in planning and delivering activities throughout the unit.

Inspectors spoke with the activities coordinators on one ward who were able to evidence the timetable of events for the upcoming week. This contained activities designed to promote better physical health such as walks and access to a gym in the unit and others which were aimed at improving mental health such as emotional regulation and better understanding of triggers which may impact upon their mental health. However, there was limited input for meaningful activities at weekends on some wards.

Additionally, inspectors observed that on one ward limited meaningful activity was planned and we were told by staff that this was generally led by nurses and dependent on staffing levels. The only activity planned was boost bingo and a weekly visit from a therapet. The focus on dementia-reducing stress and distress improvement programme is a collaboration between Healthcare Improvement Scotland, the Care Inspectorate and NHS Education for Scotland and highlights that people with dementia benefit from an environment which enables a wide range of meaningful activity in line with person-centred care. We raised this with senior managers who told us that in addition to planned activities, the approach to therapeutic activity includes unplanned person-centred activities that are guided in part by the 'getting to know me' documents. These are completed by families and patients where possible to help tailor engagement and reduce stressed and distressed behaviour. A requirement has been given to support improvement in this area.

The unit had recently become a no smoking zone with nursing and occupational therapy staff providing smoking cessation support to patients. However, the activity coordinators told us that the smoking ban has impacted on the attendance at activities as people chose to leave the grounds and smoke if able rather than attend activities.

We observed that community meetings were part of planned activities to ensure patients have an opportunity to provide feedback and ideas for improvement within the wards.

We also observed feedback boards in one ward that included 'you said we did' sections to highlight any improvements made following feedback from patients or carers. On boards throughout the wards, we also observed QR coded feedback forms which patients and carers can access and use to provide feedback on care and treatment.

We spoke with several patients who gave positive feedback about their care. They stated that they had good relationships with staff and were able to contribute to their care planning. One person did feel they weren't always listened to. We fed this back to staff.

In the adult mixed sex wards some rooms do not have ensuite facilities which means patients are required to use a shared communal toilet and shower. We spoke with one patient who stated they felt it was undignified sharing toilet and shower facilities with other patients. Inspectors fed this back to ward staff during the inspection. We raised concerns regarding mixed sex toilet and shower facilities with senior managers. We were advised there is not a risk assessment in relation to patient placement in the mixed sex wards and managers told us professional judgement and the needs of the individual were considered when patients were admitted to the unit. In response to concerns raised, we were provided with plans to reconfigure gender specific areas within the adult admission wards. However, although mitigations to preserve patient dignity and respect within mixed sex area were provided, the physical environment within some ward areas does not support full mitigation of these risks. The impact on

patient dignity and respect should be considered as a matter of urgency, along with any potential risk with regards to adult support and protection concerns, highlighted throughout this inspection. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 6	
6	Inspectors observed respectful interactions between patients and staff.
7	NHS Forth Valley have a programme of activities specifically designed to improve the physical health of patients throughout the unit.
8	Community meetings are held to allow patients to provide feedback and contribute to their care.

Requirements

Domain 6	
18	NHS Forth Valley must ensure meaningful activity is consistently provided, including weekends, and that activity plans are completed and updated.
19	NHS Forth Valley must ensure that patient's privacy and dignity is maintained, adult support and protection issues are assessed at all times including having appropriate toilet and showering facilities that support dignity and privacy in a mixed sex environment.

Appendix 1 – List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Core Mental Health Quality Standard (Scottish Government, September 2023)
- Delivering Together for a Stronger Nursing and Midwifery Workforce (Scottish Government, February 2025)
- Fire Scotland Act (Acts of the Scottish Parliament, 2005)
- Food, fluid and nutritional care standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, November 2014)
- From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care (Healthcare Improvement Scotland, January 2019)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, May 2022)
- Mental Health (Care and Treatment) (Scotland) Act (Acts of the Scottish Parliament, 2003)
- National Infection Prevention and Control Manual (NHS National Services Scotland, January 2024)
- Healthcare Improvement Scotland and Scottish Government: operating framework (Healthcare Improvement Scotland, November 2022)
- Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- Rights, risks, and freedom to limits (Mental Welfare Commission, March 2021)
- Staff governance COVID-19 guidance for staff and managers (NHS Scotland, August 2023)
- Standards for student supervision and assessment (Nursing & Midwifery Council, April 2023)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)

- The quality assurance system and framework – Healthcare Improvement Scotland (Healthcare Improvement Scotland, September 2022)

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Improvement Action Plan

Healthcare Improvement Scotland:

Unannounced Acute Mental Health Services safe delivery of care inspection

Forth Valley Royal Hospital, NHS Forth Valley

25 – 26 August 2025

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: _____

Full Name: Neena Mahal

Date: __20/01/2026_____

NHS board Chief Executive

Signature: _____

Full Name: Ross McGuffie

Date: __20/01/2026_____

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Requirement 1. Domain 1	NHS Forth Valley must ensure safe and effective policies and procedures are in place for all CCTV cameras in use. CCTV cameras must be operated in line with national regulation, guidance and local policy and staff are aware of and apply correct procedures.	March 2026	Head of Service	NHS Forth Valley Surveillance Systems Policy which was already in progress prior to the Safe Delivery of Care Inspection is being progressed through local governance routes to the whole system clinical governance working group for board oversight. NHS Forth Valley Mental Health and Learning Disability (MHLD) service will ensure the safe and effective use of this policy as well as developing and implementing a local Standard Operating Procedure (SOP) for the use of CCTV in the Mental Health Unit (MHU) by March 2026.	

Requirement 2 Domain 1	NHS Forth Valley must ensure effective governance and oversight of all necessary staff training to support all staff to safely carry out their roles. This includes but is not limited to, Basic Life Support, Public Protection, Prevention and Management of Violence and Aggression Training and Training in relation to Specialist Admissions.	February 2026 March 2026 July 2026	Chief Nurse/Head of Service	NHS Forth Valley MHLD has established weekly monitoring of individual mandatory training modules these will be included in the Workforce Governance Reports each month which reports directly into the Nursing Midwifery and Allied Health Professionals (NMAHP) Workforce Governance Committee. By March 2026 NHS Forth Valley MHLD will embed the training dashboard available via Pentana to monitor and drive improvements in training compliance. NHS Forth Valley MHLD Mandatory training compliance is currently 65% from 58% in August 2025. An initial aim of 80% compliance of all relevant staff is set for March 2026, with an aim of 95% by July 2026.	

				During the inspection process, **Adult Resuscitation** training improved from 23% to 68% while face to face training improved from 8% to 26% in January 2026 **Child and Adolescent Mental Health** training increased from 3% to 33% **Perinatal** training increased from 3% to 40% **PAMOVA** training improved from 67% to 81%. **Public Protection** training increased from 46% to 84%.	

Requirement 3. Domain 1.	NHS Forth Valley must demonstrate how it supports the ongoing development of skills and knowledge through adequate supervision and appraisal for staff	February 2026 July 2026 December 2026	Chief Nurse	NHS Forth Valley MHLD service has implemented a supervision calendar in each ward where progress is tracked. This will be reported through staff and clinical governance meetings. MHU's appraisal compliance is currently 40%. The service aim is to achieve 50% by March 2026 and 95% by July 2026. Senior staff attend the Clinical Supervision Steering Group which focuses on the implementation and evaluation of clinical supervision across all of NHS Forth Valley. The service aim for Clinical Supervision is to achieve 50% by July 2026 and 95% by December 2026.	

Requirement 4 Domain 1	NHS Forth Valley must ensure processes are in place to continue to mitigate the risk of access to the roof in the outdoor space and monitor the impact of any interventions in place	September 2025 July 2026	Head of Service	NHS Forth Valley MHLD service has implemented the risk mitigation discussed during the inspection visit which has been effective in preventing roof access in the outdoor space. The MHLD service has established a MHU Estates Oversight Group which will embed the Mental Health Built Environment Quality and Safety Assessment Toolkit Application. This group will ensure compliance in relation to any ongoing risk whereby patients can access the roof. The group meets quarterly, reporting into Health and Safety Committee for action and Clinical Governance Working Group for information and assurance.	January 2026

Requirement 5. Domain 1.	NHS Forth Valley must ensure improvement actions are compiled with and progressed with agreed timescales to reduce ligature risk identified through significant adverse event reviews and HSE improvement notices.	December 2027 March 2026	Head of Service	NHS Forth Valley MHLD Service is delivering on the necessary improvements in line with the HSE Notice of Improvement with the first stage of this work beginning in January 2026. NHS Forth Valley MHLD Service has established an Estates Oversight Group which provides oversight and assurance in relation to the suite of works in the MHU. NHS Forth Valley MHLD service is collaborating with Organisational Development to implement eLearning which has been sourced from the NHS Highland Ligature Model. This will be available to all staff by March 2026, and compliance monitored through staff and clinical governance groups.	January 2026

		December 2026		The aim is that 95% of appropriate staff will have completed this eLearning by December 2026	
Requirement 6. Domain 1.	NHS Forth Valley must ensure effective oversight of ligature risk assessments and any identified risks to ensure these are effectively mitigated	April 2026 February 2026	Head of Service	NHS Forth Valley MHLD Service will provide oversight of ligature risk assessments and associated action plans through the Health and Safety Committee for action and the Clinical Governance Working Group for information and assurance. NHS Forth Valley MHLD Service will re-establish a ligature working group which will contain key personnel who are trained to ensure consistency of risk assessment and quality of action planning. This will be reported and monitored through local clinical governance groups.	

Requirement 7. Domain 1.	NHS Forth Valley must ensure management processes to identify ongoing risk and ensure timely review, oversight and implementation of adverse event improvement actions align with the National Framework for Reviewing and Learning from Adverse Events.	February 2026: Completion of improvements within the electronic adverse event reporting system December 2026: Full implementation of aligned processes	Associate Medical Director/Chief Nurse/Head of Clinical Governance (Director of Nursing – starts March 2026)	NHS Forth Valley is reviewing and enhancing the adverse events reporting processes within Safeguard (Ulysses) to improve usability, reporting workflows, escalation pathways, investigation quality, and organisational learning. This work will ensure full alignment with the HIS National Framework by February 2026. The Adverse Event Policy and associated Significant Adverse Event Reviews and Local Management Team Review procedures have been updated to reflect the national framework and provide clear operational guidance.	

				A new training package has been identified to support consistent application across all staff groups.A benefits analysis of the nationally procured Healthcare Guardian (In-Phase) system is underway, with completion planned for February 2026. Development of an internal NHS Forth Valley Community of Practice is in progress, with MHLD learning forming a key component to support broad sharing of learning from adverse events. NHS Forth Valley continues to actively participate in the HIS-led national adverse event network.	

Requirement 8 Domain 1	NHS Forth Valley must ensure systems and processes are in place that support the effective identification and mitigation of risk to ensure a safe environment for all patients	July 2026 May 2026 March 2026 April 2026	Head of Service / Chief Nurse	NHS Forth Valley MHLD service is implementing a new formulation-based clinical risk assessment tool which includes a specific assessment of sexual safety. To support implementation, an e-learning module will be available by May 2026 and augmented with face-to-face training. Completion of training will be monitored through workforce governance reporting. NHS Forth Valley MHLD is developing a ward sexual safety charter which will be implemented by March 2026 NHS Forth Valley has ensured key stakeholders, professional structures and subject matter expertise is central to the delivery of governance, improvement and assurance. This collaboration will take place through the improvement programme governance	

		April 2026 June 2026		infrastructure. MHLD services will complete benchmarking against the Sexual Safety Standards by April 2026 NHS Forth Valley is designing an improvement programme which is informed by the National Sexual Safety Collaborative and Sexual Safety Standards. The Chief Nurse and Head of Service will provide senior leadership and oversight to ensure high quality delivery of this programme. The MHU Estates Oversight Group will make recommendations on adaptations to the MHU environment by June 2026. This will improve patient experience, privacy and prevention of harm.	January 2026

Requirement 9 Domain 1	NHS Forth Valley must ensure fire safety doors are maintained in a safe working order that enables safe fire evacuation and reduces the restriction of movement around older adult wards	May 2026	Head of Service / Director of Estates	The MHLD services have established a MHU Estates Oversight Group which will provide oversight of existing procedures and infrastructure to ensure a timely response to any improvements required.	
				The MHLD Estates oversight group will review the current fire doors and explore alternative designs and technical changes.	

Requirement 10. Domain 1.	NHS Forth Valley must ensure effective and appropriate governance approval and oversight of policies and procedures that are in place	December 2026	Head of Clinical Governance Locally Associate Medical Director	A comprehensive review of clinical guidelines and policy documents is underway, supported by a RAG-rated prioritisation approach for critical content. This has been reported through Clinical Governance Committee for assurance at board level. Processes for development, consultation, approval, and accessibility are being standardised to ensure clarity and consistency. The Clinical Governance Working Group (CGWG) will oversee this programme, with Directorate Clinical Governance Groups responsible for monitoring progress. A standing update on policy and guideline status will be included in all Directorate Clinical Governance meetings.	

				The MHLD Clinical Governance Group's Clinical Guidelines Working Group will continue to oversee the updating and management of guidelines, working towards the wider board aim for 95% of policies and guidelines to be in-date by December 2026.	

Requirement 11. Domain 2.	NHS Forth Valley must ensure that there are clear assurance processes and systems and these are planned and organised in a way that provides assurance that high quality care is being delivered	February 2026	Chief Nurse	The MHLD services will provide a Quality and Safety Assurance report to the Quality and Safety steering group, this incorporates the quality measures maintained on Pentana dashboard and the associated Safety Action plans. Assurance will be achieved through the Quality and Safety Steering group which will provide a reporting and assurance mechanism to the Quality Programme Board and the Clinical Governance Working Group and Committee. NHS Forth Valley will continue to monitor performance and progress against agreed national and local safety and quality measures (such as Scottish Patient Safety Programme and Excellence in Care).	

				The Quality and Safety Steering Group provides a platform for sharing best practice, lessons learned, and thematic insights from quality reviews and Care Assurance Visits. The group will review performance data and identify areas of limited assurance, triggering escalation through agreed governance routes. This proactive approach helps address risks early and supports improvement planning at service level by combining oversight, assurance, and improvement leadership.	

Requirement 12. Domain 2.	NHS Forth Valley must ensure there is oversight and consistent application of screening tools to identify the risk of falls or pressure sores across all wards in the MHU	June 2026 May 2026	Chief Nurse	NHS Forth Valley MHU will introduce the agreed NHS Forth Valley Falls and Pressure Injury risk screening tools across the MHU. The application of these tools will be audited and recorded with an aim of 95% compliance by June 2026. Compliance will be monitored via Clinical Governance Groups and the Quality and Safety Steering Group. NHS Forth Valley have implemented a new policy on the management of Pressure Injury and a Safer Mobility Policy. Education and support will be provided by the Practice Development Unit to support consistent application of these policies and assessment tools.	

Requirement 13. Domain 4.1	NHS Forth Valley must ensure that the care environment is in a good state of repair to support effective cleaning and that effective assurance systems are in place to support the reporting of environmental issues and the monitoring of the care environment	June 2026	Chief Nurse	NHS Forth Valley MHLD services have established a MHU Estates Oversight Group which will use the Mental Health Built Environment Quality and Safety Assessment Toolkit to review the existing procedures and infrastructure. This review will be completed by June 2026. Effective oversight of Infection Prevention and Control (IPC) will be maintained through the local operational infection control group which will act as a conduit for the board Infection Control Committee and local service delivery. This will include oversight by specialist IPC advisors and the Chief Nurse.	

Requirement 14. Domain 4.1	NHS Forth Valley must ensure consistent recording of flushing of infrequently used water outlets to improve compliance and provide assurance in line with current national guidance	August 2025	Chief Nurse	Effective oversight of Infection Prevention and Control (IPC) will be maintained through the local operational infection control group which will act as a conduit for the board Infection Control Committee and local service delivery. This will include oversight by specialist IPC advisors and the Chief Nurse NHS Forth Valley has a Water Safety Policy in place that supports the flushing of infrequently used water outlets process which is in line with national guidance. This is reviewed at the Water Safety Group to provide oversight across NHS Forth Valley.	January 2026 January 2026

		February 2026		The MHU will ensure the flushing of infrequently used water outlets is carried out on a weekly basis. Compliance will be monitored and recorded by Senior staff to achieve 95% compliance by Feb 2026	

Requirement 15. Domain 4.3	NHS Forth Valley must ensure there are clear and consistent systems and processes in place for the monitoring and mitigation of any severe and or recurring staffing risk to support longer term workforce planning.	April 2026 April 2026	Chief Nurse .	NHS Forth Valley MHLD services have implemented Safecare as a real-time staffing resource to provide oversight and real time monitoring of staffing levels to identify risks. NHS Forth Valley MHLD services record professional judgements twice daily. Daily staffing huddles across MHLD support risk mitigation and the escalation of severe risk. The service will further strengthen these processes by clarifying escalation pathways, improving documentation, and introducing regular quality assurance checks NHS Forth Valley MHLD report and monitor recurrent staffing risks via the NMAHP Workforce Governance group. NHS Forth Valley undertakes annual reviews of the	

				nursing blueprints utilising the common staffing method to identify the required workforce to mitigate recurrent staffing risks.	

Requirement 16. Domain 4.3	NHS Forth Valley must ensure there are clear, consistent systems and processes in place to support and monitor wider system oversight, of identified staffing or safety risks within the MHU	February 2026	Chief Nurse	NHS Forth Valley MHLD participates in the whole system huddle to discuss staff and safety concerns. NHS Forth Valley MHLD services have implemented Safecare as a real-time staffing resource to provide oversight and real time monitoring of staffing levels to identify risks. NHS Forth Valley MHLD services record professional judgements twice daily. Daily staffing huddles across MHLD support risk mitigation and escalation process of severe risk. NHS Forth Valley MHLD report and monitor recurrent staffing risks via the NMAHP Workforce Governance group. NHS Forth Valley undertakes annual reviews of the nursing blueprints utilising the common staffing method to identify the	

				required workforce to mitigate recurrent staffing risks.	
Requirement 17. Domain 4.3	NHS Forth Valley must demonstrate how it supports, monitors and reviews the provision of adequate time to lead and resources available to clinical leaders	March 2026	Chief Nurse	NHS Forth Valley MHLD services will ensure leadership time will be rostered and monitored t hrough a centralised monitoring system, ensuring transparency and accountability. This process will be fully implemented by March 2026.	
Requirement 18. Domain 6.	NHS Forth Valley must ensure meaningful activity is consistently provided, including weekends and that activity plans are completed and updated	April 2026 February 2026	Head of Service	By April 2026 there will be a timetable of therapeutic activities available over 7 days. NHS Forth Valley MHLD has introduced a process to monitor the consistency of activities, which is reported on via Clinical Governance.	

Requirement 19. Domain 6.	NHS Forth Valley must ensure that patients' privacy and dignity is maintained, adult support and protection issues are assessed at all times including having appropriate toilet and showering facilities that support dignity and privacy in a mixed sex environment.	March 2026 June 2026	Head of Service	NHS FV has undertaken work to ensure that patient placement is informed by privacy, dignity and patient safety across the Acute Mental Health Wards. NHS Forth Valley MHLD service will undertake a comprehensive review of the evidence relating to mental health admission ward provision. This review will consider current practice, national guidance, patient experience and safety considerations.	
Recommendation 1 Domain 2.	NHS Forth Valley should consider the benefit of extending access to reflective session to staff in older adult wards within the mental health unit	June 2026	Director of Psychology / Chief Nurse	NHS Forth Valley MHLD service will expand access to this to include all MHU wards by June 2026	

Appendix 3

Local Action Plan Summary of Progress

The Improvement Action Plan was developed following the HIS: Unannounced Mental Health Safe Delivery of Care Inspection and signed by the Board Chair and Chief Executive on 20th January 2026. The actions require to be implemented across the Board and all actions are on track to deliver within agreed timescales. Ongoing monitoring will be through the Clinical Governance Working Group and Clinical Governance Committee.

Action	Timescale to meet action	Status
1. NHS Forth Valley must ensure safe and effective policies and procedures are in place for all CCTV cameras in use. CCTV cameras must be operated in line with national regulation, guidance and local policy and staff are aware of and apply correct procedures.	March 2026	**On Track** Organisational Policy in place. Assurance around local implementation on track for March 2026.
2. NHS Forth Valley must ensure effective governance and oversight of all necessary staff training to support all staff to safely carry out their roles. This includes but is not limited to, Basic Life Support, Public Protection, Prevention and Management of Violence and Aggression Training and Training in relation to Specialist Admissions.	July 2026	**On Track** Currently at 65% compliance, on track to achieve 95% compliance by July 2026. Weekly monitoring of compliance is underway through Workforce Governance.

3. NHS Forth Valley must demonstrate how it supports the ongoing development of skills and knowledge through adequate supervision and appraisal for staff.	July 2026 Sep 2026 Dec 2026	**On Track** Appraisal (PDP) is to achieve 50% compliance by March 2026 and 95% by July 2026. HCSW standard compliance will be complete for 95% of HCSW staff by September 2026. The service aim is to achieve 50% Clinical Supervision compliance by July 2026 and 95% by December 2026.
4. NHS Forth Valley must ensure processes are in place to continue to mitigate the risk of access to the roof in the outdoor space and monitor the impact of any interventions in place.	Jan 2026 Jan 2026 July 2026	**On Track** **Complete:** Anti-ligature paint applied to outdoor space and signage introduced **Complete:** The MHLD service has established a Mental Health Unit Estates Oversight Group. This group will ensure compliance in relation to any ongoing risk whereby patients can access the roof. The group meets quarterly, reporting into Health and Safety Committee for action and Clinical Governance Working Group for information and assurance. Recommendations regarding additional control measures are on track to be made by July 2026.
5. NHS Forth Valley must ensure improvement actions are compiled with and progressed with agreed timescales to reduce ligature risk identified through significant adverse event reviews and HSE improvement notices.	March 2026 Dec 2027	**On Track** NHS Forth Valley MHLD service is collaborating with Organisational Development to implement eLearning which has been sourced from the NHS Highland Ligature Model. NHS Forth Valley is delivering on the necessary improvements in line with the HSE Notice of Improvement.

6. NHS Forth Valley must ensure effective oversight of ligature risk assessments and any identified risks to ensure these are effectively mitigated.	Feb 2026 April 2026	**On Track** **Complete:** NHS Forth Valley MHLD Service have re-established a ligature risk oversight working group to ensure consistency of risk assessment and quality of action planning. NHS Forth Valley MHLD Service will provide oversight of ligature risk assessments and associated action plans through the Health and Safety Committee for action and the Clinical Governance Working Group for information and assurance.
7. NHS Forth Valley must ensure management processes to identify ongoing risk and ensure timely review, oversight and implementation of adverse event improvement actions align with the National Framework for Reviewing and Learning from Adverse Events.	Feb 2026 Dec 2026	**On Track** Mental Health Unit Dashboard established to review and analyse adverse events. NHS Forth Valley is reviewing and enhancing the adverse events reporting processes within Safeguard (Ulysses) to improve usability, reporting workflows, escalation pathways, investigation quality, and organisational learning. **Complete:** The Adverse Event Policy and associated Significant Adverse Event Reviews and Local Management Team Review procedures have been updated to reflect the national framework and provide clear operational guidance.
8. NHS Forth Valley must ensure systems and processes are in place that support the effective identification and mitigation of risk to ensure a safe environment for all patients.	March 2026 April 2026 May 2026	**On Track** NHS Forth Valley MHLD is developing a ward sexual safety charter which will be implemented by March 2026. MHLD services will complete benchmarking against the Sexual Safety Standards by April 2026. NHS Forth Valley MHLD service is implementing a new formulation-based clinical risk assessment tool which includes a specific assessment of sexual safety. Associated training will be provided and monitored.

	June 2026	The MHU Estates Oversight Group will make recommendations on adaptations to the MHU environment by June 2026. This will improve patient experience, privacy and prevention of harm.
9. NHS Forth Valley must ensure fire safety doors are maintained in a safe working order that enables safe fire evacuation and reduces the restriction of movement around older adult wards	May 2026	**Complete** Fire doors checked and confirmed to be fully functional. Any future issues will be escalated and addressed via the MHU Estates Oversight Group.
10. NHS Forth Valley must ensure effective and appropriate governance approval and oversight of policies and procedures that are in place.	Dec 2026	**On Track** The service will have 95% of policies and guidelines in date by December 2026.
11. NHS Forth Valley must ensure that there are clear assurance processes and systems and these are planned and organised in a way that provides assurance that high quality care is being delivered.	Feb 2026	**On Track** The Mental Health Unit will provide a Quality and Safety Assurance report to the NHSFV Quality and Safety steering group on a regular basis. This will be based on improved routine assurance reporting utilising appropriate systems such as Pentana, and including measures from SPSP and Excellence in Care.
12. NHS Forth Valley must ensure there is oversight and consistent application of screening tools to identify the risk of falls or pressure sores across all wards in the MHU.	June 2026	**On Track** NHS Forth Valley MHU will introduce the agreed NHS Forth Valley Falls and Pressure Injury risk screening tools across the MHU. The application of these tools will be audited and recorded with an aim of 95% compliance by June 2026. Compliance will be monitored via Clinical Governance Groups and the Quality and Safety Steering Group.

13. NHS Forth Valley must ensure that the care environment is in a good state of repair to support effective cleaning and that effective assurance systems are in place to support the reporting of environmental issues and the monitoring of the care environment	June 2026	**On Track** The Mental Health Unit Estates Oversight Group will use the Mental Health Built Environment Quality and Safety Assessment Toolkit to review the existing procedures and infrastructure. This review will be completed by June 2026. **Complete:** Effective oversight of Infection Prevention and Control (IPC) will be maintained through the local operational infection control group which will act as a conduit for the board Infection Control Committee and local service delivery.
14. NHS Forth Valley must ensure consistent recording of flushing of infrequently used water outlets to improve compliance and provide assurance in line with current national guidance	Feb 2026	**On Track** The MHU ensures the flushing of infrequently used water outlets is carried out on a weekly basis. Compliance is monitored and recorded by Senior staff to achieve 95% compliance by Feb 2026.
15. NHS Forth Valley must ensure there are clear and consistent systems and processes in place for the monitoring and mitigation of any severe and or recurring staffing risk to support longer term workforce planning.	April 2026	**Complete** NHS Forth Valley MHLD services have implemented Safecare as a real-time staffing resource to provide oversight and real time monitoring of staffing levels to identify risks. Recurrent staffing risks are reported and monitored via the NMAHP Workforce Governance group. Staffing establishments are reviewed annually to identify the required workforce to mitigate recurrent staffing risks.
16. NHS Forth Valley must ensure there are clear, consistent systems and processes in place to support and monitor wider system oversight, of identified staffing or safety risks within the MHU.	Feb 2026	**Complete** The Mental Health Unit participates in the whole system huddle, which reviews and considers staff and safety concerns across the Forth Valley Royal Hospital site, including escalation where necessary.

17. NHS Forth Valley must demonstrate how it supports, monitors and reviews the provision of adequate time to lead and resources available to clinical leaders	March 2026	**On Track** NHS Forth Valley MHLD services will ensure leadership time will be rostered and monitored through a centralised monitoring system, ensuring transparency and accountability. This process will be fully implemented by March 2026.
18. NHS Forth Valley must ensure meaningful activity is consistently provided, including weekends and that activity plans are completed and updated	Feb 2026 April 2026	**On Track** **Complete:** NHS Forth Valley Mental Health Unit has introduced a process to monitor the consistency of activities, which is reported via Clinical Governance. By April 2026 there will be a timetable of therapeutic activities available over 7 days.
19. NHS Forth Valley must ensure that patients' privacy and dignity is maintained, adult support and protection issues are assessed at all times including having appropriate toilet and showering facilities that support dignity and privacy in a mixed sex environment.	June 2026	**On Track** NHS Forth Valley MHLD service will undertake a comprehensive review of the evidence relating to mental health admission ward provision. This review will consider current practice, national guidance, patient experience and safety considerations.
20. NHS Forth Valley should consider the benefit of extending access to reflective session to staff in older adult wards within the mental health unit.	June 2026	**On Track** Access to this will be expanded to include all MHU wards by June 2026.

NHS Forth Valley

Forth Valley NHS Board

12. Spotlight on Services: Ward Product Manager
Purpose: This report is for Assurance

Executive Sponsor: Scott Urquhart, Director of Finance
Authors: David Logie, Head of Procurement, and Stevie McIntosh, Logistic Manager

Executive Summary

The Ward Product Management Service is a well-established service that directly supports clinical care, delivers significant cost savings, and aligns with the principles of Value Based Health and Care. The service consistently improves efficiency, reduces waste, and frees nursing time to focus on patients, demonstrating clear system-wide benefits worthy of Board recognition.

The service was set up over 17 years ago to support nursing staff in releasing time to care and consists of the Customer Service Manager, and 5 Ward Product Managers

NHS Forth Valley is one of only a few boards which offer a level 1 service and holds a ten-day supply of stock. The Level 1 service is built around four core elements: count, order, deliver and maintain, and has adopted this structured approach to stock management. NHS Forth Valley was the original test site for implementing the model, with the primary aim of releasing time to care by reducing the stock-related workload placed on clinical teams. The purpose of the Ward Product Manager (WPM) role is to provide all aspects of stock management for each ward/department. All stock purchased is via the National Distribution Centre (NDC) to ensure best value and practices are followed. Every stocked item within the ward/department has had an annual usage set up with the NDC to make sure supply chain demands are robust.

The WPM's have a structured process to ensure all aspects of stock management are carried out which include inventory stock management, rationalisation, rotation of stock and procurement savings. The service has implemented new processes in the management of stock which have resulted in an increase in cost savings. The impact of savings minimises wastage and maximises efficiency through the redistribution of specialised vac dressings, reducing the carbon footprint, reporting and implementing the National Procurement Contractual changes.

The design of the process has had an immediate and positive impact on stock management within the wards, enabling staff to work more efficiently and consistently. This structured approach supports improved patient experience by ensuring that high-quality care is delivered seamlessly.

The WPM team is key in the management of Personal Protective Equipment (PPE) for flu and Covid outbreaks within NHS Forth Valley. A stock is held at Forth Valley Royal Hospital (FVRH) and Central Supplies Department ((CSD), Stirling to support any major events ensuring the service reacts efficiently and immediately eg the recent flu outbreak during November and December 2025.

The team work closely with the Bladder and Bowel Service (BABs) to manage and monitor continence product stock, reflecting the rising value of these items driven by increased raw material costs and growing patient demand. The WPM service ensures that wards use the correct products and appropriate quantities, supporting both clinical requirements and cost-effectiveness. Specialist, patient-specific products are also managed carefully to meet individual clinical needs while maintaining financial oversight.

Action Required

The Forth Valley NHS Board is asked to:

(1) recognise the significant value and positive impact the Ward Product Management Service has on the day-to-day management of services and departments across NHS Forth Valley;

(2) note that key Clinical Leads for the introduction of any new National Contracts will be identified, enabling product evaluations to be undertaken in advance of board-wide implementation.

(3) consider whether the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

Chief Executive previously visited the department and invited staff to present to the board.

Risk Assessment and Mitigation

Describe any relevant risk assessment/mitigations.

Risks: H&S challenges within storerooms/service including hazards arising from poor layout, obstructed walkways, and inappropriate storage of equipment, which increase the likelihood of slips, trips and falls. Manual handling, infection prevention and control, and fire safety concerns are all associated risks within the management of storerooms.

Mitigations: Risk assessments carried out by management to ensure safety of employees is paramount to ensure that all H&S protocols area adhered to and utilise the Safeguard reporting tool to highlight risks.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty

Does this report require an EQIA or Fairer Scotland Duty Assessment? No

If yes, please confirm this is attached. Attached☐ Not required x

Financial and Infrastructure Implications

WPM is key to major national contract changes and the process of moving from key national contracts from one Supplier to another via NDC. The financial impact of any cost changes/savings are tracked via procurement reports to Finance.

Appendix 1: Details tables showing savings for the financial year 2024/25 - £21,028 and 2025/26 - £19,306 (as of December 2025)

Workforce Implications

- Positive impact on nursing staff and releases time to care.
- Saving benefit opportunities through stock rotations and looking at slow-moving stock in wards/departments.
- To achieve additional saving opportunities additional resource would be required.

Quality / Patient Care Implications

- Improve patient outcomes: Ensure urgent stock requirements are met in a timely and efficient manner to support wards/services.
- Replacement of stocked products, offering a reliable replacement product to meet clinical needs.

Population Health & Care Strategy

The Service is underpinned by the principles of Value Based Health and Care as outlined below:

- Aligns with Value Based Health & Care by supporting clinical areas in providing patient focussed person centred care.
- Offers significant cost savings across the system through efficient management of ward-based stock.
- Working collaboratively locally, nationally within the NHS and the National Distribution Service.

Climate Change / Sustainability Implications

The Ward Product Management System contributes to reducing NHS Forth Valley's carbon footprint through improved stock efficiency. Furthermore, the implementation of National Procurement Contractual changes supports the organisation in maintaining sustainability and ensuring that clinical service requirements continue to be met.

Engagement and Communications

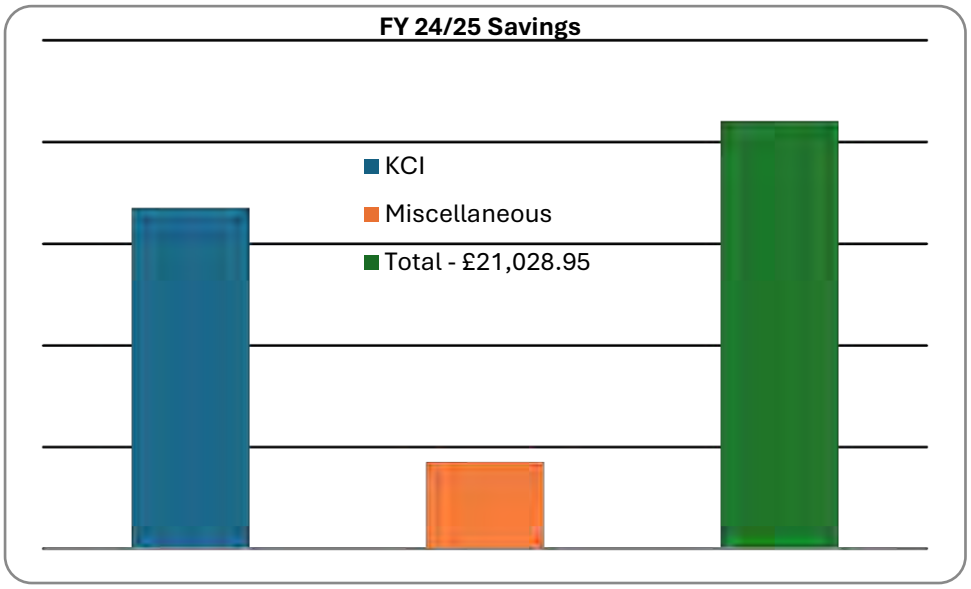
Was statutory engagement with stakeholders required? Yes ☐ No X

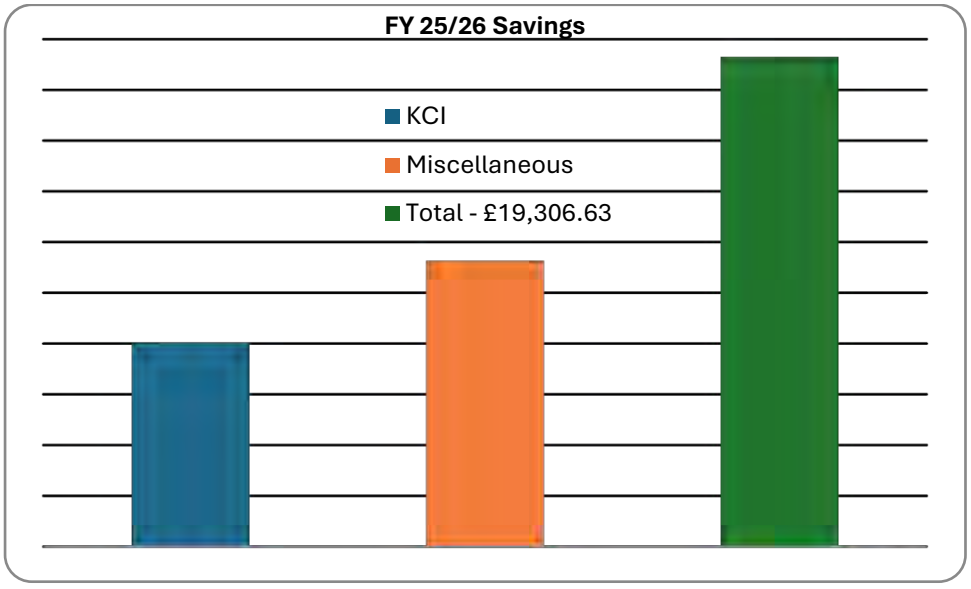
Engagement Activity:

Launch of Ward Product Manager short film on our webpage on staff intranet.

Appendix 1

The below column graph highlights the savings via specialised wound management dressings and also the miscellaneous savings through redistribution of stocked products to various wards/areas throughout Forth Valley.





NHS Forth Valley

Forth Valley NHS Board

13. Finance Report
Purpose: This report is for Assurance

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Scott Urquhart, Director of Finance / Jillian Thomson, Deputy Director of Finance

Executive Summary

This report provides an overview of the month 10 financial results and an updated forecast outturn for the year.

The 2025/26 year-end outturn projection remains consistent with the position reported to the NHS Board on 27th January 2026, projecting a break-even outturn against revenue and capital resource limits at 31st March 2026, subject to final outstanding risk areas. Further work has progressed in relation to quantification of expected IJB risk sharing requirements for 2025/26 and on confirmation of outstanding funding allocations.

NHS Forth Valley's draft three-year financial plan was submitted to Scottish Government in early February, with key points presented for discussion at a Board Seminar on 10th February. The plan highlights a significant ongoing financial challenge, supported by a revised savings plan which continues to be refined in advance of the final submission date of 16th March 16th with onward submission to NHS Board for approval on 31st March.

A Quarter 3 financial review meeting was held with Scottish Government colleagues on 13th February to review the in-year financial position, assess progress on delivery of savings plans, and to discuss initial feedback on draft financial plans for 2026/27.

Initial discussions on sub-national financial plans are taking place with Scotland West Boards to identify initial priority areas for review and opportunities for improvement. Further updates will be provided through the Strategic Planning, Performance and Resources Committee as this area of work develops and progresses.

Action Required

Forth Valley NHS Board is asked to:

(1) note that a break-even position against both revenue and capital sources is projected for 2025/26 subject to identified risks in the last 2 months of the year.
(2) note the ongoing work in relation to financial planning in advance of final plan submission.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration
This matter has previously been considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- The SPP&RC and the NHS Board receive regular updates on the financial position, plans and risk as a standing agenda item.

Risk Assessment and Mitigation
Financial sustainability continues to be reported as very high risk in the NHS Board's strategic risk register. This reflects the financial impact of ongoing operational service and demand pressures.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications
The Capital and Revenue financial implications are considered in the main body of the report.

Workforce Implications
There are no immediate workforce implications associated with this report. However, it is recognised that workforce costs account for a significant proportion of total operating expenditure and is therefore a key financial risk area.

Quality / Patient Care Implications
It is imperative that quality of care and overall service provision is underpinned by a sustainable financial strategy aligned to the principles of Value Based Health and Care.

Population Health & Care Strategy
It is recognised that improving population health outcomes and shifting resources to early intervention/more preventative measures can reduce future demand on services. Adopting the principles of values-based health and care and Realistic Medicines is a key feature of our financial planning process.

Climate Change / Sustainability Implications
There are no direct climate change/sustainability implications arising from this report. Climate Change and Sustainability initiatives contribute to efficiency savings, reducing waste, cost avoidance and productivity gains across the five priority areas for NHS Scotland (i.e. Sustainable Buildings & Land; Sustainable Travel; Sustainable Goods & Services; Sustainable Care; and Sustainable Communities). A range of climate change and sustainability initiatives are already included in our cost improvement programme.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒
This report was prepared in consultation with Senior Finance colleagues.

Appendices
Appendix 1 – Overview of Financial Performance.

Appendix 1 - Overview of Financial Performance

1. NHS FV Financial Performance

The total annual budget for 2025/26 is estimated at £989.7m as summarised in table 1 below. Note that the overall budget includes a small number of anticipated revenue allocations that still require formal confirmation by the Scottish Government.

The estimated annual budget increased by £14.2m compared to the previous month, with a range of favourable movements between anticipated and confirmed allocation values for pay awards and other policy developments, including planned care initiatives and non-recurring sustainability funding (see annex A).

TABLE 1: NHS Forth Valley 2025/26 Finanical performance	Annual Budget £m	April - January Budget £m	April - January Expenditure £m	Underspend/ (Overspend) £m	Forecast Outturn £m
Set Aside & Non-Delegated Functions*					
Acute Services	268.370	221.652	234.458	(12.807)	(18.346)
Woman Children and Families	68.114	56.599	56.694	(0.095)	(1.038)
Cross Boundary Flow/External SLAs	75.242	62.572	62.445	0.128	(0.091)
Non-delegated Community Services	42.224	36.307	37.135	(0.828)	(0.911)
Facilities	116.546	97.128	97.810	(0.682)	0.003
Digital	27.015	22.163	21.385	0.778	0.764
Corporate Functions	42.256	34.070	32.142	1.928	2.588
Ringfenced and Contingency Budgets **	45.509	9.550	0.000	9.550	16.886
Income	(40.560)	(33.802)	(33.983)	0.181	0.145
Sub total	**644.715**	**506.239**	**508.086**	**(1.846)**	**0.000**
Delegated Functions					
Operational Services	150.773	124.976	118.274	6.702	
Universal Services	189.540	163.114	168.831	(5.716)	
IJB reserves	4.659	(0.985)	0.000	(0.985)	
Sub total	**344.972**	**287.105**	**287.105**	**0.000**	
Reserve transfers (to)/from IJB					
Clackmannanshire & Stirling IJB	0.000	0.000	0.000	0.000	
Falkirk IJB	0.000	0.000	0.000	0.000	
Sub total	**0.000**	**0.000**	**0.000**	**0.000**	
TOTAL	**989.687**	**793.344**	**795.191**	**(1.846)**	

* Note that these budgets include specialties defined as "large hospital services" which form part of IJB Set Aside budgets. The total Set Aside budget included in the total of £644.715m above is £88.4m. An overspend of £7.612m is reported at month 10.

**The forecast outturn for Ringfenced &Contingency budget reflects expected slippage in allocations &favourable changes in financial planning assumptions &other unplanned financial benefits eg CNORIS contributions and New Medicines Fund (via additional receipts due under the Voluntary Scheme for Branded Medicines Pricing, Access, and Growth).

As outlined in table 1 above, an overspend of £1.8m is reported for the 10-month period ending 31 January 2026 (this represents an improvement of £0.7m compared to the position reported in the previous month). The majority of the overspend relates to ongoing pressures within the Acute Services Directorate (including women children & families), however material overspends are also reported in relation to Externals/Cross Boundary Flow, other non-delegated Community Services and Facilities. Key drivers of the overspend in these Directorates relate to pay costs (particularly in relation to medical staffing and unregistered nursing), drugs and

devices (in terms of uptake of new drugs in Oncology and Dermatology and Diabetes technologies), ongoing pressures regarding non-emergency patient transport and increased costs of SLAs with neighbouring NHS Boards and external providers.

In terms of the forecast outturn for the year, breakeven continues to be projected based on current financial results, together with projected savings delivery and recent confirmation of funding allocations and favourable changes in financial planning assumptions.

The position will be kept under close review between now and 31 March 2026, however the estimated impact of these risks is expected to be managed within the overall outturn projection.

In term of progress in reducing supplementary staffing costs, the latest information to 31 January 2026 confirms that expenditure is £5.2m or 16.7% lower than the same period in the previous year as summarised in Table 2 below.

Table 2: Non-Core Staffing Costs	Apr 24 to Jan 25 £	Apr 25 to Jan 26 £	Better/ (Worse) £	% Change
Admin agency	35,864	5,725	30,138	84.0%
Admin bank	1,060,507	920,919	139,588	13.2%
Medical agency	3,814,756	4,690,488	(875,732)	(23.0%)
Medical bank	2,040,588	2,765,611	(725,023)	(35.5%)
Medical locum	1,908,744	1,008,309	900,435	47.2%
Nurse agency	2,400,217	16,757	2,383,460	99.3%
Nurse bank	16,828,678	14,005,233	2,823,445	16.8%
Other agency	231,434	235,926	(4,492)	(1.9%)
Other bank	1,124,031	1,018,826	105,204	9.4%
Overtime	1,462,985	1,083,590	379,395	25.9%
Total	**30,907,804**	**25,751,384**	**5,156,420**	**16.7%**

The reduction is largely driven by the continued cessation of nurse agency; however, nurse bank cost reductions are also a positive factor with expenditure down £2.8m compared to the same period in the previous year. This reflects targeted work in this area by the Nursing Workforce Governance group to ensure that nurse bank usage remains appropriately authorised and cross referenced against sickness absence, vacancies and backfill requirements.

Overall medical supplementary pay costs remain higher than the previous year and action is now underway to recruit to additional substantive posts to reduce costs in key specialities as part of an invest to save proposal.

2. Efficiency Savings

The Financial Sustainability Action Plan for 2025/26 sets out the broad range of local and national cost improvement initiatives and efficiency schemes to mitigate the initial £38.0m funding gap identified as part of the development of our 2025/26 financial plan.

The action plan includes savings schemes across 4 workstreams which are aligned to the refreshed national "15-point grid" and the 3% recurring savings target set by the Scottish Government. To date total savings of £24.7m have been delivered which is £5.8m behind the planned trajectory. The majority of workstreams are behind plan to varying degrees with the exception of nurse agency staffing, prescribing and non-pay and other measures workstreams.

Annual plan £m	TABLE 3: 2025/26 Finanical Sustainability Action Plan - YTD saving delivery	Apr - Jan plan £m	Apr - Jan actual £m	Variance £m
	15 Box Grid: Innovation & Value-Based Healthcare			
0.035	Clinical Variation Review	0.029	0.024	(0.005)
0.392	Digital savings	0.327	0.105	(0.222)
1.965	Energy Efficiency Schemes	1.638	0.000	(1.638)
3.691	Prescribing savings	2.154	3.819	1.665
6.083	**Sub total: Innovation & Value-Based Healthcare**	**4.147**	**3.948**	**(0.199)**
	15 Box Grid: Workforce Optimisation			
0.999	Agency Reduction	0.833	2.383	1.551
4.949	Sustainable staff bank usage	4.124	2.828	(1.296)
0.500	Sickness absence reduction	0.375	0.000	(0.375)
1.044	Non-compliant rotas review	0.870	0.000	(0.870)
0.000	Central functions job family review	0.000	0.000	0.000
7.492	**sub total: Workforce Optimisation**	**6.202**	**5.211**	**(0.991)**
	15 Box Grid: Service Optimisation			
0.500	Theatres optimisation	0.417	0.051	(0.366)
1.909	Remote outpatient appointments	1.591	0.000	(1.591)
0.200	PLICS roll out	0.200	0.200	0.000
0.000	Length of stay reductions	0.000	0.000	0.000
0.221	Non-pay spend review	0.184	0.118	(0.066)
2.830	**sub total: Service Optimisation**	**2.392**	**0.369**	**(2.023)**
	Other local savings plans			
2.482	Estates & Infrastructure	2.250	1.467	(0.782)
8.603	Service redesign & reform	7.169	1.468	(5.701)
10.409	Non-pay & other measures	8.262	12.150	3.888
0.163	Savings under development	0.122	0.120	(0.002)
21.657	**sub total: Other local savings plans**	**17.803**	**15.206**	**(2.597)**
38.062	**TOTAL**	**30.544**	**24.734**	**(5.809)**
21.899	Recurring	18.609	18.404	**(0.205)**
16.163	Non-recurring	11.935	6.331	**(5.604)**
38.062	**TOTAL**	**30.544**	**24.734**	**(5.809)**

Of the £24.7m total saving achieved to date, £18.4m (74%) is classed as recurring (at this stage last year approximately £12m of recurring savings were delivered). Excellent progress has been made in relation to ongoing impact of nurse agency reductions with further savings reported this year. In addition, Prescribing savings through implementation of a range of technical switches and the review of stock management and off contract spend are also being delivered in line with plan.

Key areas of concern include the workforce optimisation savings category in terms of the risk around non-compliant rotas and high sickness absence levels in certain service areas. The service optimisation category is also under review, particularly in relation

to the saving attached to remote outpatient appointments which is considered high risk in terms of likely delivery of cash releasing savings. Service redesign and reform through the Value Based Health and Care programme is now underway, with the savings delivered to date relating to the closure of ward A11 as part of whole system work to shift the balance of care (note that estimated savings delivered in year will reduce following the temporary reopening of A11 to provide additional surge capacity as part of winter planning).

3. Directorate Financial Performance

3.1. Clinical Directorates (Set Aside & Non-Delegated Functions)

Clinical Directorates reported a combined overspend of £3.9m as at 31 January 2026 as summarised in Table 4 below.

TABLE 4: Clinical Directorates*	Annual Budget £m	April - January Budget £m	April - January Expenditure £m	Underspend/ (Overspend) £m	Forecast Outturn £m
Acute Services	268.370	221.652	234.458	(12.807)	(18.346)
Woman Children and Families	68.114	56.599	56.694	(0.095)	(1.038)
Cross Boundary Flow/External SLAs	75.242	62.572	62.445	0.128	(0.091)
Non-delegated Community Services	42.224	36.307	37.135	(0.828)	(0.911)
Ringfenced and Contingency Budgets	45.509	9.550	0.000	9.550	16.886
Income	(40.560)	(33.802)	(33.983)	0.181	0.145
Sub total	**458.898**	**352.879**	**356.749**	**(3.871)**	**(3.355)**

* Note that these budgets include specialties defined as "large hospital services" which form part of IJB Set Aside budgets. The total Set Aside budget included in the total above is £88.4m. An overspend of £7.612m is reported at month 10.

Acute services – an overspend of £12.8m is reported as at end January 2026 (a favourable movement of £2.8m compared to the position reported in December). The position reflects a £10m overspend in respect of Emergency Care & Inpatient Services and an overspend of £2.8m relating to Planned Care Services. Key pressure areas include pay costs, particularly in respect of medical staffing which is overspent by £5.2m and nurse pay budgets (primarily relating to unregistered nursing staff) which are overspent by £1.9m to date due to ongoing use of contingency areas and other unfunded services (including the flow navigation centre). Proposals to address unfunded areas have been agreed by the Financial Stewardship Group and work is now underway across several SLWGs to take forward the redesign process. Pressures are also reported in relation to the cost of drugs and devices (particularly in relation to the uptake of oncology drugs and diabetes technology such as insulin pumps and continuous glucose monitors).

Women, Children & Families – an overspend of £0.1m is reported at end of January 2026, which is a favourable movement of £0.8m compared to the position reported in December). The overspend is largely driven by non-pay items including complex care packages provided through external providers, surgical sundries (mainly Paediatric Diabetes technologies) and equipment.

Cross boundary flow/external SLAs – this budget covers treatment for Forth Valley residents out with Forth Valley, mainly through service agreements for planned treatment with other Scottish Health Boards, and unplanned activity (UNPACS). An

underspend of £0.1m is reported at the end of January 2026, representing a favourable movement of £0.5m compared to the position reported in December. This movement is mainly driven by the allocation of interim inflation funding, pending finalisation of the NHS Scotland rate. For financial planning purposes, it is anticipated that cost increases will be incurred from 2026/27 onwards as SLAs are updated following the removal of the Covid pause and as NHS Scotland transitions to a new Patient Level Costing System (PLICS).

Non-delegated community services – an overspend of £0.8m is reported as at 31 January 2026. This is largely due to ongoing financial pressures in Prison healthcare settings due to the new prison pharmacy contract, changes to working practices and the impact of decisions taken by the Scottish Prison Service (SPS) to realign the prisoner population across the entire Scottish prison estate in order to relieve accommodation pressures (resulting in additional prisoners being transferred to Polmont and Glenochil above historic establishment levels).

Ringfenced and contingency budgets – this refers to centrally held funding for key policy developments that have slipped or where amounts have still to be formally confirmed by the Scottish Government (e.g. the national LIMS replacement programme and CNORIS). Any additional unplanned funding received in year from the Scottish Government is also included in this line, together with Annually Managed Expenditure (AME) which typically relates to non-cash or technical accounting items. £9.5m has been released from this budget in the month 10 reports.

Income – income received at end January 2026 is broadly in line with the planned level. Note that we have rebased the 3-year average activity levels used to calculate SLA payments from other NHS Boards for services provided by Forth Valley, this is expected to generate additional income in year.

3.2. Set Aside & Non-Delegated Functions - Corporate Directorates

A combined underspend of £2m is reported for Corporate Services, Facilities and Digital Directorates as at 31 January 2026 as summarised in table 5 below.

TABLE 5: Corporate Functions and Facilities & Infrastructure	Annual Budget £m	April - January Budget £m	April - January Expenditure £m	Underspend/ (Overspend) £m	Forecast Outturn £m
Facilities	116.546	97.128	97.810	(0.682)	0.003
Digital	27.015	22.163	21.385	0.778	0.764
Corporate Functions					
Director of Finance	7.334	6.086	6.102	(0.016)	(0.112)
Area Wide Services	0.825	(0.085)	0.645	(0.730)	(0.780)
Medical Director	13.956	11.587	10.095	1.492	1.938
Director of Public Health	3.272	2.666	2.515	0.151	0.244
Director of HR	7.187	5.988	5.722	0.266	0.289
Director of Nursing	5.913	4.759	4.569	0.190	0.261
Chief Executive	0.886	0.711	0.605	0.106	0.160
Strategic Planning & Performance	2.883	2.358	1.888	0.470	0.588
Corporate Functions sub total	42.256	34.070	32.142	1.928	2.588
Sub total	**185.817**	**153.361**	**151.337**	**2.024**	**3.355**

Facilities – an overspend of £0.7m is reported at the end of January 2026 which is a favourable movement of £0.118m compared to the position reported in December. Ongoing pressures remain in relation to non-emergency patient transport, clinical waste, postages and energy. A number of immediate actions were taken forward to strengthen financial controls around 1st class and 2nd class postage (mainly relating to letters), however overall postage costs remain higher than the same period in the previous year which appears to be due to the costs of parcels and other bulky deliveries. New franking machines have been installed which will enable more granular data on postage costs to be investigated and support targeted savings initiatives in this area.

Digital - an underspend of £0.8m is reported at the end of January 2026 (which is broadly in line with the position reported at end December) due to non-recurring underspends in Health Records and eHealth due to the lead in time to fill vacancies.

Corporate Functions – a combined underspend of £1.9m is reported at the end of January (an improvement of £0.5m compared to the position reported in December). This is largely driven by non-recurring underspends in the Medical Director budget in relation to vacancies in Pharmacy, Quality and Innovation and the Information Governance teams. This is offset by timing issues relating to legal claims and associated provisions which accounts for the majority of the overspend reported against the Area Wide Services budget.

3.3. Delegated Functions – Health & Social Care Partnerships

Delegated health functions reported under the Health and Social Care Partnerships (HSCPs) returned a combined overspend of £0.98m as at 31 January 2026 as summarised in table 6 below, however this is assumed to be offset by corresponding reserve movements which brings both HSCPs to breakeven.

TABLE 6: Health & Social Care Partnerships	**Annual Budget**	**April - January Budget**	**April - January Expenditure**	**Underspend/ (Overspend)**
Clackmannanshire and Stirling HSCP				
Operational Services	67.744	55.565	52.272	3.294
Universal Services	95.949	82.499	86.779	(4.280)
Ringfenced and Contingency Budgets	2.501	0.987	0.000	0.987
Subtotal	166.195	139.050	139.050	0.000
Falkirk HSCP				
Operational Services	83.029	69.411	66.002	3.408
Universal Services	93.591	80.616	82.052	(1.436)
Ringfenced and Contingency Budgets	2.157	(1.972)	0.000	(1.972)
Subtotal	178.777	148.054	148.054	0.000
TOTAL	**344.972**	**287.105**	**287.105**	**0.000**

The HSCP budgets summarised in table 6 exclude budgets in respect of large hospital services, also referred to as Set Aside, which amount to £88.4m. Responsibility for the operational and financial management of Set Aside functions currently resides with NHS Forth Valley.

In terms of the year-to-date position for delegated functions, the key financial challenge experienced by both HSCPs continues to relate to Primary Care prescribing which accounts for the overspend reported under universal services in table 6. This reflects ongoing volume growth in the number of items prescribed, tariff adjustments as part of the Community Pharmacy funding settlement and short supply issues. Delays in achieving prescribing efficiency savings also contribute to the adverse position reported to date.

As reported in table 6, the pressure on the primary care prescribing budget is offset by non-recurring underspends on operational services in Clackmannanshire and Stirling HSCP due to vacancies and slippage in recruitment within community District Nursing Services, Mental Health services and community based AHP services.

Similarly, Falkirk HSCP are also experiencing ongoing vacancies and associated non-recurring underspends in community Mental Health services, community based AHP services, community Learning Disability services and Health Improvement.

In terms of potential risk sharing arrangements, an upfront payment was made to both IJBs during the 2024/25 financial year for projected risk share requirements in 2025/26 (based on the historic the risk share agreement for each IJB). However current projections for Clackmannanshire and Stirling IJB suggest that a further risk share payment may be required (currently estimated at £1.7m).

4. Capital Financial Performance

The total net capital budget for 2025/26 is currently estimated at £14.0m as summarised in table 7 below. This reflects the core formula allocation of £6.7m as advised by the Scottish Government, together with £7.3m of net anticipated allocations (including £6.3m of approved funding through the Business Continuity Plan submission and £0.7m via the National Infrastructure Board).

TABLE 7: 2025/26 NHS Forth Valley Capital Position	**Annual Budget £m**	**April - Jan Budget £m**	**April - Jan Expenditure £m**	**Underspend/ (Overspend) £m**
Elective Care	0.000	0.345	0.345	0.000
Information Management & Technology	5.761	2.071	2.071	0.000
Medical Equipment	4.319	2.413	2.413	0.000
Facilities & Infrastructure	5.239	2.247	2.247	0.000
NHS Board corporate projects	(0.601)	0.004	0.004	0.000
Right of Use Assets IFRS16	0.307	0.252	0.252	0.000
Total Available Capital Funding	**15.025**	**7.331**	**7.331**	**0.000**
Indirect Capital Charged to Revenue	(1.000)	0.000	0.000	0.000
Forecast NET Capital Resource Limit	**14.025**	**7.331**	**7.331**	**0.000**

As reported in Table 7 above, a balanced position is reported against the Capital Resource Limit (CRL), with total expenditure of £7.3m reported to date, leaving a net balance of £6.7m to be spent during the remaining 2 months of the financial year. Note that slippage of £2.7m is expected, therefore equivalent funding will be returned to the Scottish Government to be carried forward to 2026/27.

Key areas of expenditure to date are described below:

Elective Care – £0.3m has been incurred to date on advisor and professional fees due to ongoing delays associated with the new National Treatment Centre Inpatient Ward. The delay reflects outstanding technical issues relating to the pipework and fire compliance regulations. A potential solution has been submitted to Falkirk Council's building control team for review and we are currently awaiting feedback.

Information Management & Technology – to date the sum of £2.0m has been spent on a range of infrastructure refresh projects, primarily relating to the new Radiology Information System (RIS), upgraded Picture Archiving and Communication System (PACS) and the new Digital Pathology system. Slippage of £1.7m is currently expected in relation to Order Comms and LIMS replacement due to national delays in these projects.

Medical Equipment – £2.4m has been incurred to date in relation to replacement beds, new Ultrasound Probes and Max Fax dental equipment. Procurement of other medical equipment, in line with the planned replacement plan, is scheduled for the final quarter of the financial year in line with supplier lead in times.

Facilities & Infrastructure – to date the sum of £2.2m has been spent on improvements works at Dunblane Health Centre, professional fees in relation to the proposed ASDU extension, improvements to the footpaths at the Bungalows, Legionella Remedial works, refurbishment of the Resident Doctors accommodation at FCH and the initial roll out of the anti-ligature works at FVRH. Projected Slippage on a number of schemes has been identified and c£1.0m will be handed back to the Scottish Government to be carried forward into 2026/27 to complete these projects.

NHS Board Corporate Projects and Property Sales – the overall budget includes planned capital to revenue grants (reported as a negative budget in table 7 above). Note that there are currently no anticipated capital receipts linked to property sales during 2025/26. Discussions with property developers have concluded in relation to sale of land at Stirling Care Village with a preferred bidder identified and approved, however the sale is not expected to conclude until late 2026/27.

Annex A – In year revenue financial allocation movements

NHS Forth Valley 2025/26 reconciliation of Annual Budget movement	Budget Movement £m
Total estimated revenue budget as at month 9	**975.443**
New Scottish Government allocations	
System pressures funding	10.000
Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG)	1.533
Test & Learn Prevention	0.227
Camhs Regional Programme Funding	0.238
Sub total	**11.997**
Movement between anticipated and confirmed allocation value	
CNORIS Participation (AME funding)	1.210
Immunisation funding	1.083
Heart Failure Diagnostics - Heart Disease Action Plan	0.046
Scottish National Radiology Reporting Service	(0.003)
Health & Care Staffing Act Implementation	(0.089)
Sub total	**2.247**
Total net budget movement during month 10	**14.244**
Revised total estimated revenue budget as at month 10	**989.687**

NHS Forth Valley

Forth Valley NHS Board

14. Performance Report
Purpose: This report is for Assurance

Executive Sponsor: Ross McGuffie, Chief Executive
Author: Kerry Mackenzie, Acting Director of Strategic Planning & Performance; Claire Alexander, Senior Performance Manager; Garry Fraser, Director of Acute Services; Marie Gardiner, Head of Acute Services; Deborah Lynch, Unscheduled Care, Programme Manager; Fiona Murray, Head of Emergency Care & Inpatients.

Executive Summary

NHS Forth Valley routinely reports performance against a range of non-financial performance metrics. The Performance Report is presented to update the Committee in respect of NHS Forth Valley's performance against a range of national and local measures with information provided to support effective monitoring and management of system-wide performance.

The overall approach to performance within NHS Forth Valley underlines the principle that performance management is integral to the delivery of quality improvement and core to sound management, governance, and accountability.

The scorecard provides an 'at a glance' view of measures with work on-going to ensure accuracy of data, and that all the definitions and reporting periods remain appropriate and meaningful. The scorecard is continually reviewed to ensure appropriate revisions or amendments are included in a responsive and timely manner.

Action Required

The Forth Valley NHS Board is asked to:

(1) consider the latest performance data within the Performance Report noting the Area of Focus – Urgent & Unscheduled Care and Priority Areas of Performance.
(2) consider the progress made in reducing the number of patients waiting over 52 weeks for a new inpatient appointment and for an inpatient/daycase procedure.
(3) consider if the report provides assurance that appropriate controls are in place to manage the identified risks, support the delivery of objectives and where improvements are needed, clear actions have been identified.

Governance Route to the Meeting and Previous Board Consideration

This paper has previously been considered by the Senior Leadership Team on 16 February 2026 with questions invited.

Risk Assessment and Mitigation

Adequate monitoring, scrutiny and management of performance supports the organisation to manage its risk with performance reporting linked to Strategic Risks:

SRR.002 Urgent & Unscheduled Care
If NHS Forth Valley does not have enough whole system capacity and flow to address key areas of improvement there is a risk that we will be unable to deliver safe, effective,

and person-centred unscheduled care resulting in a potential for patient harm, increases in length of stay, placement of patients in unsuitable places, and a negative impact on patients and staff experience.

SRR.004 Scheduled Care
If NHS FV does not consider and plan for current and future changes to population and associated demand/case-mix, there is a risk that the model for delivery of planned care will not meet demand or prioritise effectively, resulting in poorer patient outcomes, avoidable harm and failure to meet targets.

In addition, there is linkage to Organisational Risks in respect of Waiting Times, Radiology/Imaging Capacity, Delayed Discharge, Mental Health Services – Psychological Therapies and the 62-day cancer target.

These risks are reviewed and updated by the responsible risk owners with the Strategic Risk Register update presented as a standing item to NHS Board Assurance Committees and the NHS Board.

Impact Assessments

Equality & Diversity and Fairer Scotland Duty
Does this report require an EQIA or Fairer Scotland Duty Assessment? No
If yes, please confirm this is attached. Attached☐ Not required ☒

Financial and Infrastructure Implications
Financial implications and sustainability are being considered on an ongoing basis working closely with Scottish Government colleagues and Health & Social Care Partnership Chief Finance Officers. The Finance Report is a standing item on the Performance & Resources Committee and Forth Valley NHS Board meeting agendas.
Financial Breakeven is detailed on the Strategic Risk Register as a Very High risk for NHS Forth Valley. As such it is reviewed and managed as a risk assigned to the Strategic Planning, Performance & Resources Committee.

SRR.005: Financial Breakeven
If our recurring budget is not sufficient to meet the recurring cost base there is a risk there will be an increasing recurring gap in our finances, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service provision.

Workforce Implications
Workforce is a limiting factor in our ability to delivery services with specific workforce issues aligned to areas of performance highlighted within the report. The Workforce Plan 2026/27 is currently being developed, and it is anticipated that the draft will be presented to the Staff Governance Committee in March ahead of issue in April 2026.

Quality / Patient Care Implications
There are no specific quality or patient care implications in respect of this paper.

Population Health & Care Strategy
Monitoring performance and the ongoing development of relevant performance frameworks will support the monitoring of local and national strategy implementation.

Climate Change / Sustainability Implications
Describe any implications in relation to climate change / sustainability.

Engagement and Communications
Was statutory engagement with stakeholders required? Yes ☐ No ☒

- If yes, please provide details.

Cognisance has been taken of feedback and comments from Non-Executive and Executive Director colleagues.

Appendices
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Performance Report

February 2025

Report format

- The report is split into 4 sections
    - Section 1: Performance Summary
    - Section 2: Area of Focus
    - Section 3: Performance Report
        - Priority Areas of Performance
        - Other Areas of Performance
    - Section 4: Performance Scorecard

- Section 1: Performance Summary
    - Section 1 provides a summary overview of key areas of performance.

- Section 2: Area of Focus
    - Section 1 will focus on a particular area of performance with a detailed discussion in respect of areas of challenge and key areas of improvement.

- Section 3: Performance Report
    - This section details key performance issues, measures, and graphs.
    - Measures, graphs and key performance issues narrative are linked and should be viewed collectively.
    - The Scotland comparison has been included where possible in the Key Performance Measures and Key Performance Graphs sections. Note that the Scotland figures are typically a month or quarter behind.

- Section 4: Performance Scorecard
    - The Performance Scorecard details the measure, target, current position (monthly or quarterly), previous reported position, previous year position and the Scotland position (where available).
    - The notes section provides a definition and detail in relation to the indicators and targets.

Performance data and graphs continue to be developed within the Pentana Performance and Risk Management System with graph and table detail from Pentana informing the report.

Section 1: Performance Summary

Area of Focus – Urgent & Unscheduled Care

January is typically a period of higher demand across the whole health and care system, driven by winter illness, increased patient acuity, and reduced community and social care capacity following the festive period. The variation and deterioration observed across multiple performance measures this month should therefore be understood within the context of these predictable seasonal pressures, rather than viewed as a regression in system performance.

- **Emergency Department 4-hour Standard**: Performance declined in January, with Forth Valley compliance decreasing from 59.3% in December to 56.9% in January. This reflects sustained pressures on whole-system flow and capacity.

- **Average Length of Stay (LoS):** Mean emergency LoS increased to 7.5 days in January, although late-December performance demonstrated the system's ability to achieve significantly lower weekly LoS (6.0 → 5.4 days). Continued focus on discharge reliability is needed to reach the 7.0-day March 2026 trajectory.

- **Hospital Occupancy:** Acute occupancy rose sharply in January, reversing the gains observed immediately after Criteria to Reside implementation. Although occupancy had dropped to 95.5% in December, January levels returned above the 107.3% mean.

- **Total Delayed Discharges:** Delayed discharges increased again in January. The rolling mean remains 113, representing a 22.6% reduction (33 fewer delayed discharges) exceeding the target.

- **Acute Delayed Discharges:** The mean average daily delayed discharges have reduced from a baseline of 33 to 28, representing a 14.7% improvement. While this reflects positive progress, performance remains below the March 2026 target of a 25% reduction (approximately 25).

- **Hospital at Home:** Utilisation remained strong at 82.9%–92.4%, slightly below the optimal 90–95% range. Work continues toward expanding capacity to 112 beds by December 2026.

- **Flow 1 (Minors):** Performance decreased slightly from 86.5% to 84.1%, though MIU continues to support ED flow during seasonal peaks.

- **Time to First Assessment:** Median time increased to 123 minutes, driven by high occupancy and overnight backlog.

- **Pre-noon Discharges:** Improved to 17.7%, up from 15.6%, but still below the 20% target.

- **Length of Stay greater than 14 days:** A seasonal rise in long-stay patients was recorded in January, consistent with winter acuity and community delays.

- **Contingency Beds:** Usage increased again in January, reflecting whole-system pressure.

Priority Areas of Performance

Unscheduled Care

Overall compliance with the 4-hour emergency access standard (EAS) in January 2026 was 56.9%; Minor Injuries Unit 99.7%, Emergency Department 45.0%. A total of 2,985 patients waited longer than the 4-hour target across both the ED and Minor Injuries Unit (MIU); with 1,526 waits longer than eight hours, 784 waits longer than 12 hours and 150 waits longer than 23 hours. The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,866 patients, noting this was 1,311 in January 2025. Wait for a bed accounted for 647 patients waiting beyond 4 hours with clinical reasons accounting for 127 breaches. In January there were 521 new attendances to Rapid Assessment and Care Unit (RACU), 137 of which were via ED. It is worth noting 915 patients that attended ED did not wait in January 2026 compared with 659 in January 2025.

Delayed Discharges

The January 2026 census position in relation to standard delays (excluding Code 9 and guardianship) is 54 delays; this is compared to 84 in January 2025. There was a total of 57 code 9 and guardianship delays, with the total number of delayed discharges noted as 111. The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the January 2026 census was 1,644, this is a reduction from 2,097 in January 2025.

Scheduled Care

At the end of January 2026, the number of patients on the waiting list for a first outpatient appointment was 17,599 (17,074 excluding mutual aid) compared with 12,661 in January 2025 with the number waiting beyond 12 weeks 7,023 (6,730 excluding mutual aid) compared to 7,738 in January 2025.

In January 2026, the number of inpatients/daycases waiting was 7,730 (7,457 excluding mutual aid and NTC) compared with 6,616 in January 2025. An increase from the previous year in those waiting beyond 12 weeks from 4,189 to 4,982 was also noted.

At the end of December 2025, 1,583 patients were waiting beyond the 6-week standard for imaging with 46 patients were waiting beyond 6 weeks for endoscopy.

Cancer target compliance in December 2025:

- 62-day target – 66.2% of patients waited less than 62 days from urgent suspicion of cancer referral to first cancer treatment. This is compared with the December 2024 position of 78.8%.
- 31-day target – 100%.

The position for the October to December 2025 quarter is that 70.3% of patients were treated within 62 days of referral with a suspicion of cancer. This is a decrease from 85.9% the previous quarter. During the same period, 99.7% of patients were treated within 31 days of the decision to treat.

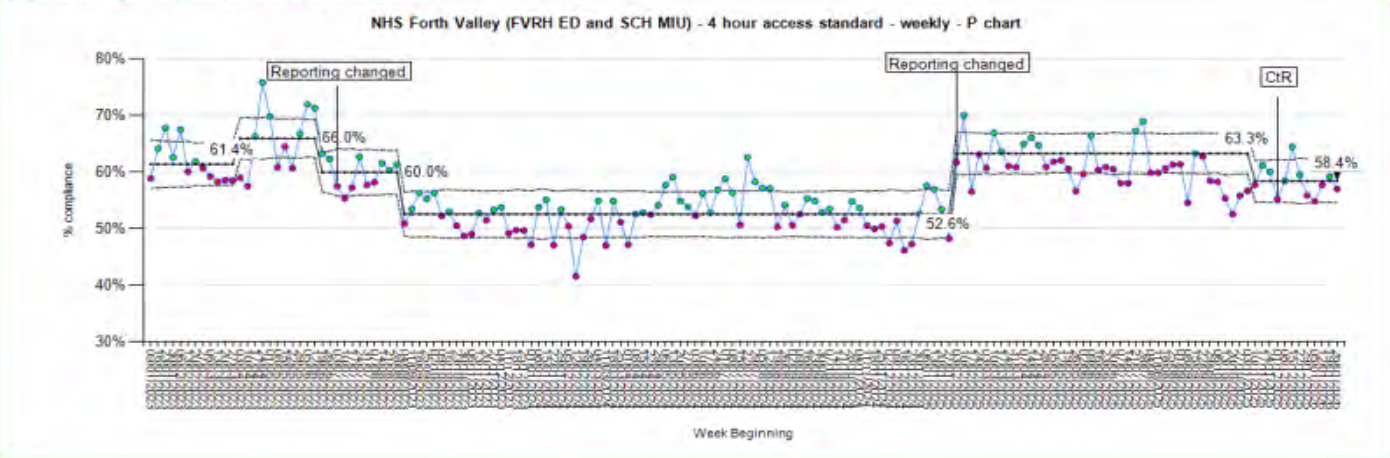
Psychological Therapies

In December 2025, data shows that 77.5% of patients started treatment within 18 weeks of referral.

Section 2: Area of Focus Urgent and Unscheduled Care

1. Whole System Measurement

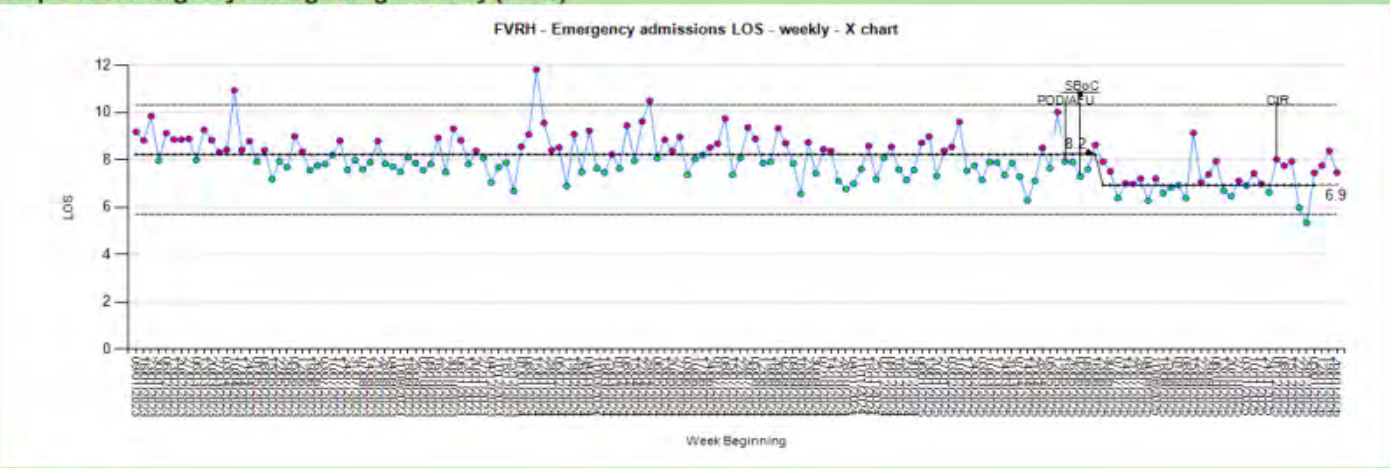
Graph 1.1: Emergency Access Standard



Forth Valley compliance against the 4-hour standard dropped from **59.3% in December** to **56.9% in January 2026, highlighting that urgent and unscheduled care services remain under significant pressure**.

This decline reflects the continued strain on Emergency Department capacity and the wider system, despite the progress made through Criteria to Reside (CtR) and associated flow improvements.

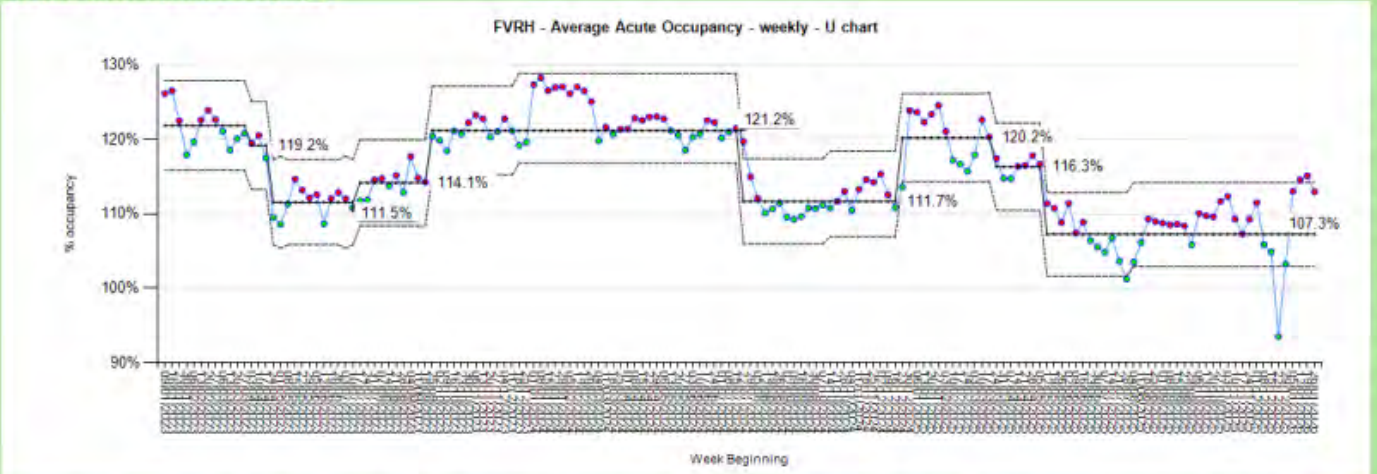
Graph 1.2: Emergency Average Length of Stay (ALoS)



The month-on-month rise to **7.5 days in January** should be read alongside the **late-December weekly lows (6.0 → 5.4 days)**, which indicate the system can achieve shorter stays when discharge reliability and downstream capacity align. To reach the **March trajectory of 7.0 days**, we need an average reduction of ~0.25 days per month from the January position, supported by consistent application of CtR, earlier senior decision-making, and timely access to downstream pathways.

1. Whole System Measurement (continued)

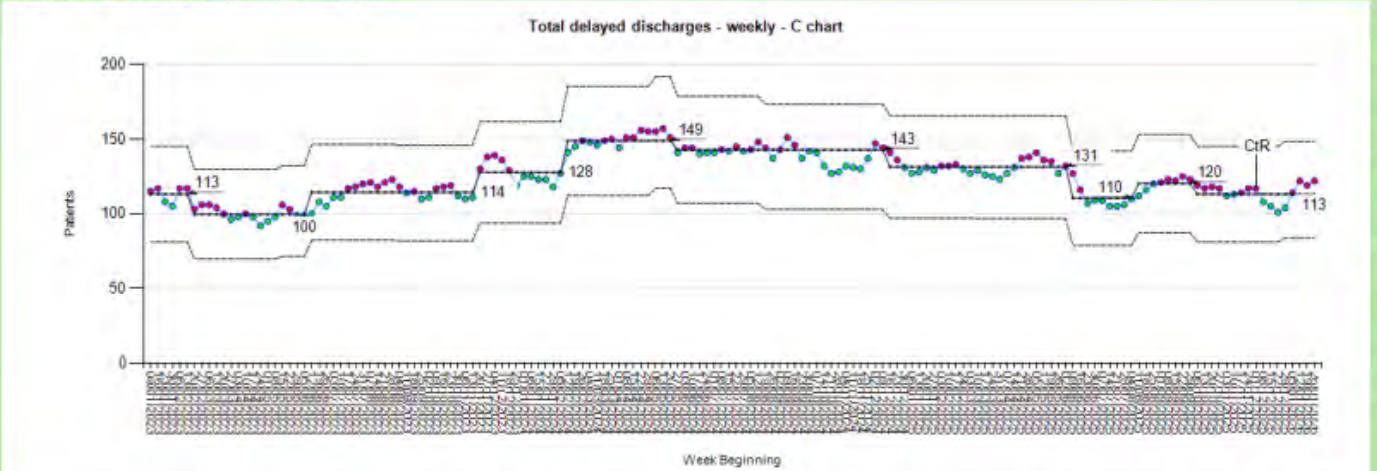
Graph 1.3: Hospital Occupancy



There has been a sharp rise in hospital occupancy during January, reversing the significant reductions achieved immediately after the introduction of Criteria to Reside (CtR). Occupancy had previously fallen well below the mean of **107.3%**, reaching lows of **95.5%,** demonstrating that the system *can* operate within a safer and more stable range when downstream flow is reliable and discharge processes are functioning well.

The challenge now is to recover this earlier progress and stabilise performance. Achieving the **target of 95% occupancy by March 2026** will require renewed focus on discharge reliability, improved access to community capacity, and consistent application of CtR to minimise avoidable delays.

Graph 1.4: Total Delayed Discharges

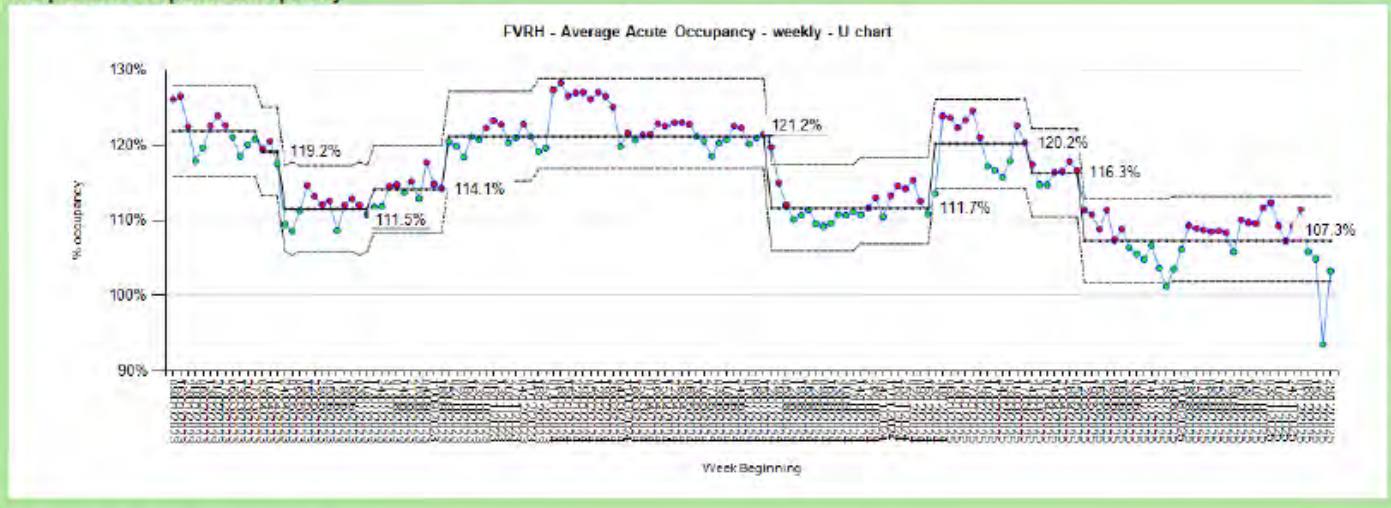


We have seen an increase in the total number of delayed discharges during January, signalling renewed pressure within the system. Despite this uptick, performance remains close to the planned improvement trajectory. The target is a **20% reduction** in delayed discharges by January 2026 from a baseline of 146, and the current mean of **113** represents a **22.6% reduction (33 fewer delayed discharges) exceeding the target.**

A breakdown of acute and community hospital delays can be seen in Graph 5.2 and Graph 5.3 respectively, on page 13 and 14.

1. Whole System Measurement (continued)

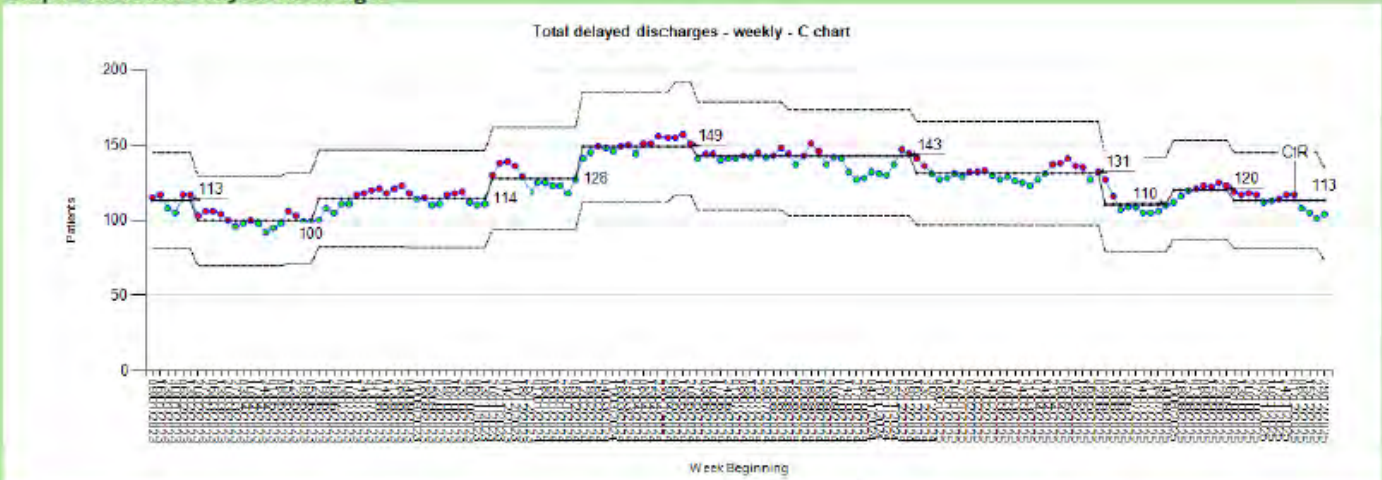
Graph 1.3: Hospital Occupancy



Since the introduction of CtR, average acute occupancy at FVRH has reduced significantly. Levels have fallen below the current mean of **107.3%**, with the lowest point reaching **93.5%**. This step-change demonstrates the impact of CtR in accelerating discharge readiness, freeing acute beds, and improving patient flow across the hospital.

The target of 95% Occupancy by March 2026, will require a continued focus on discharge reliability, and community flow to maintain momentum and achieve this goal.

Graph 1.4: Total Delayed Discharges



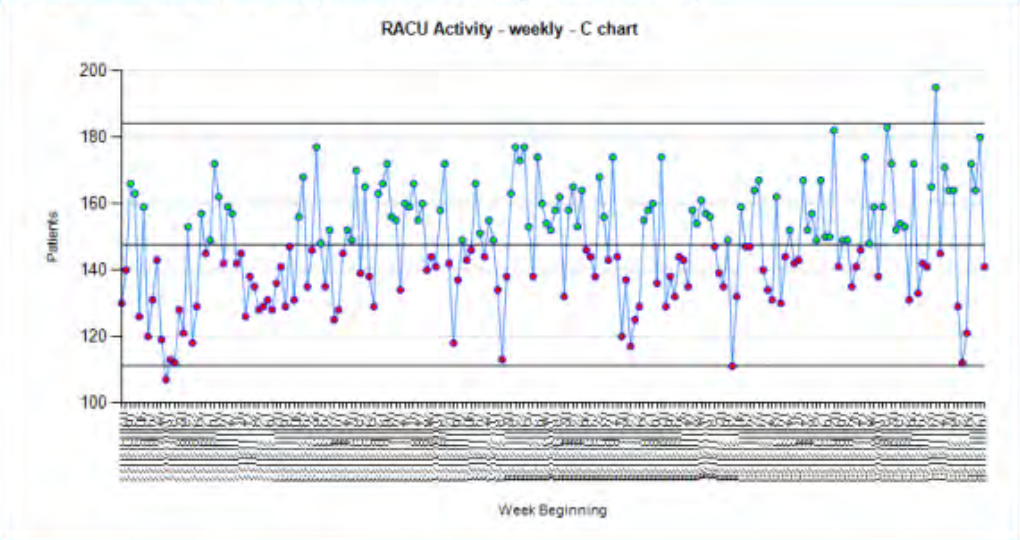
Since the introduction of CtR, the total number of delayed discharges has decreased. Significantly, the latest four data points are all below the current mean of 113,

The target trajectory is a **25% reduction in delayed discharges by January 2026**, based on a baseline of 146. The current mean of 113 reflects a 22.6% reduction. Although this is slightly below the target, it demonstrates substantial progress and positions us within reach of achieving the goal.

A breakdown of acute and community hospital delays can be seen in Graph 5.2 and Graph 5.3 respectively, on page 13 and 14.

2. Flow Navigation Centre (FNC) Workstream Measurement

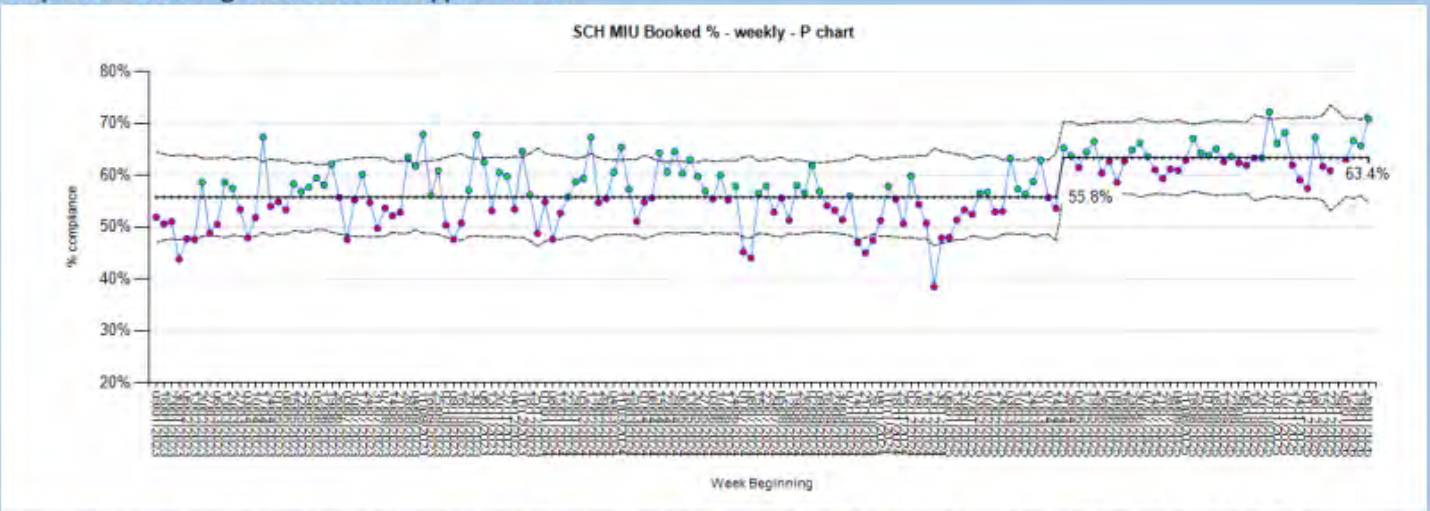
Graph 2.1: Number of RACU patients per week (new and return)



Our PHS Discovery data indicates that NHS Forth Valley has a higher proportion of GP admissions directly to RACU compared to other boards, which has had a positive impact on reducing ED attendances.

Key constraints:
At present, we do not have access to electronic data that would allow us to fully evaluate the utilisation and effectiveness of our RACU pathways. Strengthening data capture and visibility will be key to understanding how these pathways are functioning in practice.

Graph 2.2: Percentage of MIU booked appointments



We've seen a sustained increase in the proportion of booked appointments to MIU, with the mean rising from **55.8% to 63.4%.**

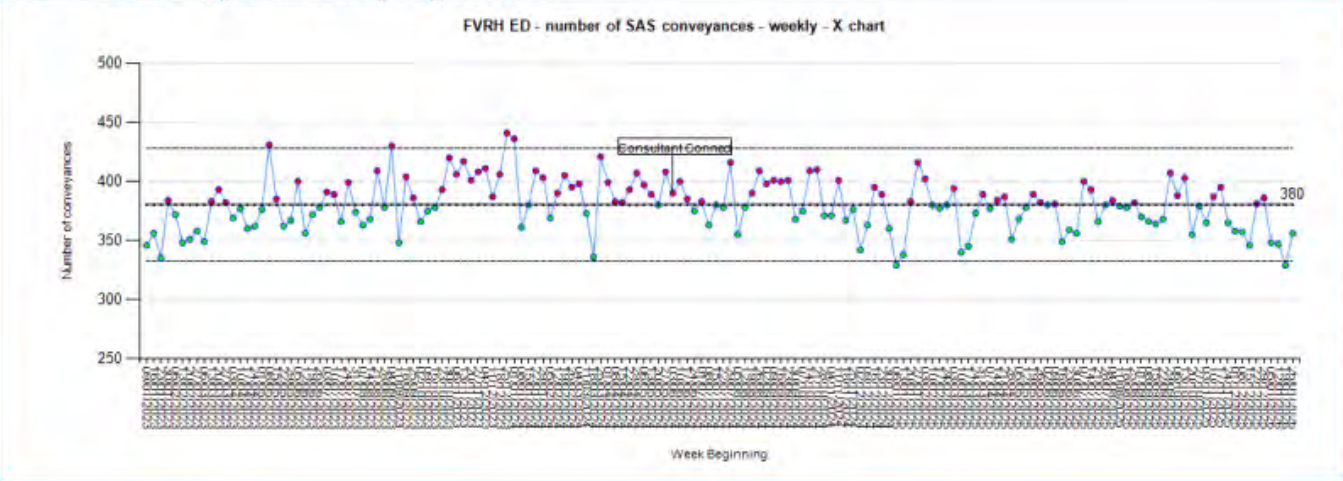
We have a high performing minor injury unit pathway which has a positive impact on our 4-hour performance.

Improvements have been made to online and phone booking processes, including a walk-in with booking option. Appropriate patients are being directed to MIU at ED triage to reduce pressure on the department.

Patient education and awareness about when to use MIU and the benefits of booking appointments continues.

2. Flow Navigation Centre (FNC) Workstream (continued)

Graph 2.3 Number of patients conveyed by SAS to ED



SAS conveyances show a recurring seasonal dip across December and early January, consistent with festive-period service patterns. Recent weeks are below the long-run mean **(380/week)**, but remain within expected control limits, indicating seasonal common-cause variation rather than a step-change. We will continue to monitor for any sustained run below the centerline that would suggest a true shift.

Workstream constraints:

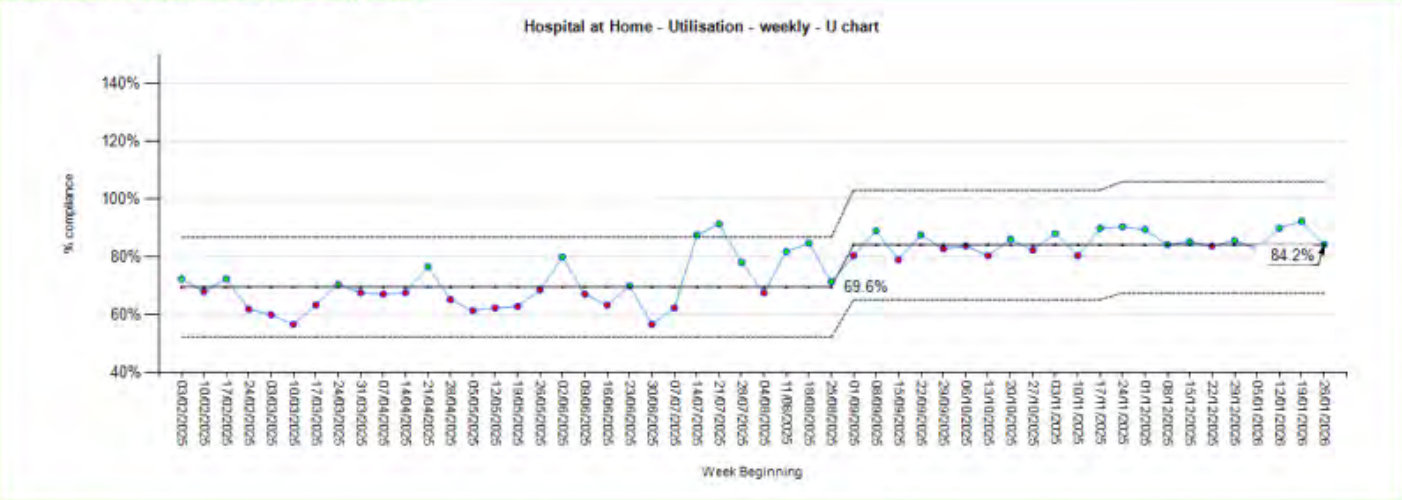
- Our FNC model is not a Senior Clinical Decision Maker (SCDM) model – due to the limitations of data collection we don't understand what impact this has on attendances to our urgent and unscheduled care services. We suspect that as we are currently limited with links to alternative pathways (for out of hospital care) that most routes are to the front door of the acute hospital.
- We don't have access to electronic data to fully understand our FNC activity. This includes outcomes of calls to the FNC and how well our RACU pathways are working/utilised.
- We have a limited number of RACU pathways due to workforce capacity.

Next steps:

- Design and implement a SCDM model within the FNC framework to enhance early decision-making, reduce unnecessary admissions, and optimise patient flow across urgent care pathways.
- Pilot Near Me Video Consultations in Flow Navigation Centre (ED clinic).
- Develop and scale up SDEC models and other services that support zero-day LoS, enabling patients to be assessed, treated, and discharged on the same day where clinically appropriate. This will reduce unnecessary admissions, improve patient experience, and support flow across the urgent care system.
- Scale up the use of Consultant Connect across urgent and unscheduled care pathways to support timely clinical decision-making, reduce unnecessary ED attendances, and improve access to specialist advice.
- Maintain and enhance the scheduling of appointments to MIU to improve patient flow, reduce waiting times, and minimise unscheduled attendances.
- Access to electronic FNC data to support national and local data collection requirements.

3. Hospital at Home Workstream

Graph 3.1 – Hospital at Home Capacity



Hospital at Home utilisation ranged from **82.9% to 92.4%** in January. While this indicates strong occupancy, it falls slightly below the optimal range **(90–95%)**. Further review is needed to understand whether this reflects seasonal demand variation, staffing constraints, or process factors limiting throughput.

Current Older Adult Hospital at Home Capacity is 30 beds.

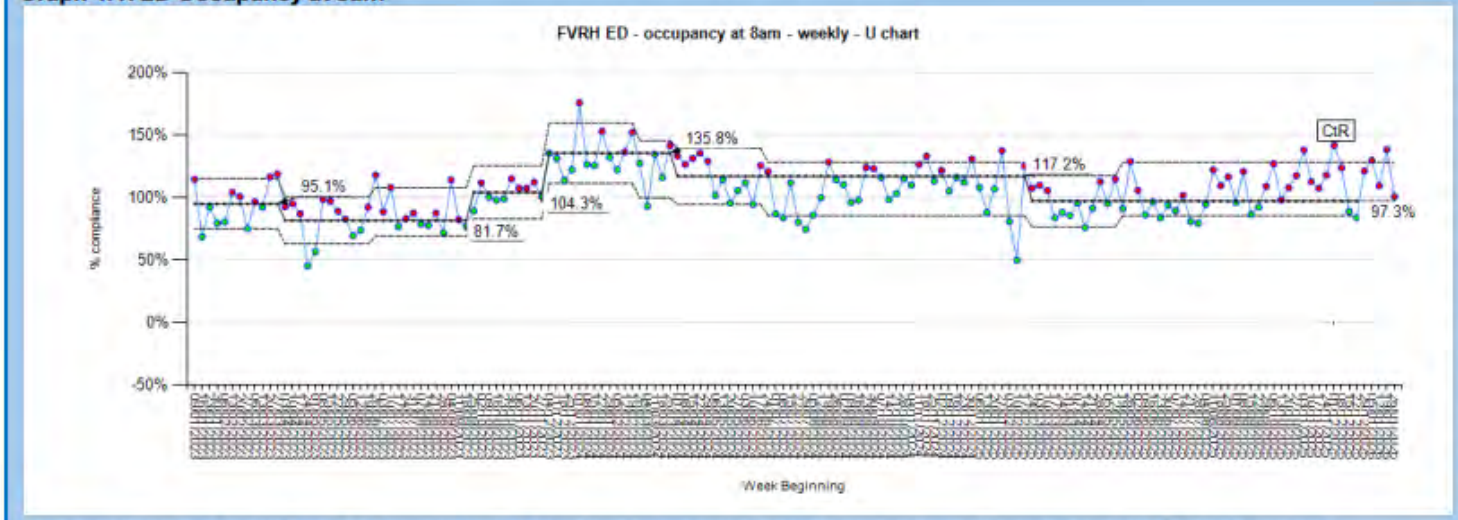
Next steps:

Forth Valley have been allocated additional funding to **increase Hospital at Home Capacity to 112 beds, by December 2026.** This expansion will include access to specialist pathways in Outpatient Parenteral Antimicrobial Therapy (OPAT), respiratory, and heart failure services. It will also include the development of admission avoidance and early supported discharge pathways across OPAT, respiratory, and heart failure domains, in alignment with national definitions of Hospital at Home+.

Local project plans to support the expansion are in development and Forth Valley have applied to join the new National Hospital at Home Programme 2025 – 2026 with Healthcare Improvement Scotland. Electronic virtual wards will be developed for each of the services as a platform for managing patient data, coordinating care and tracking key indicators.

4. Front Door Workstream

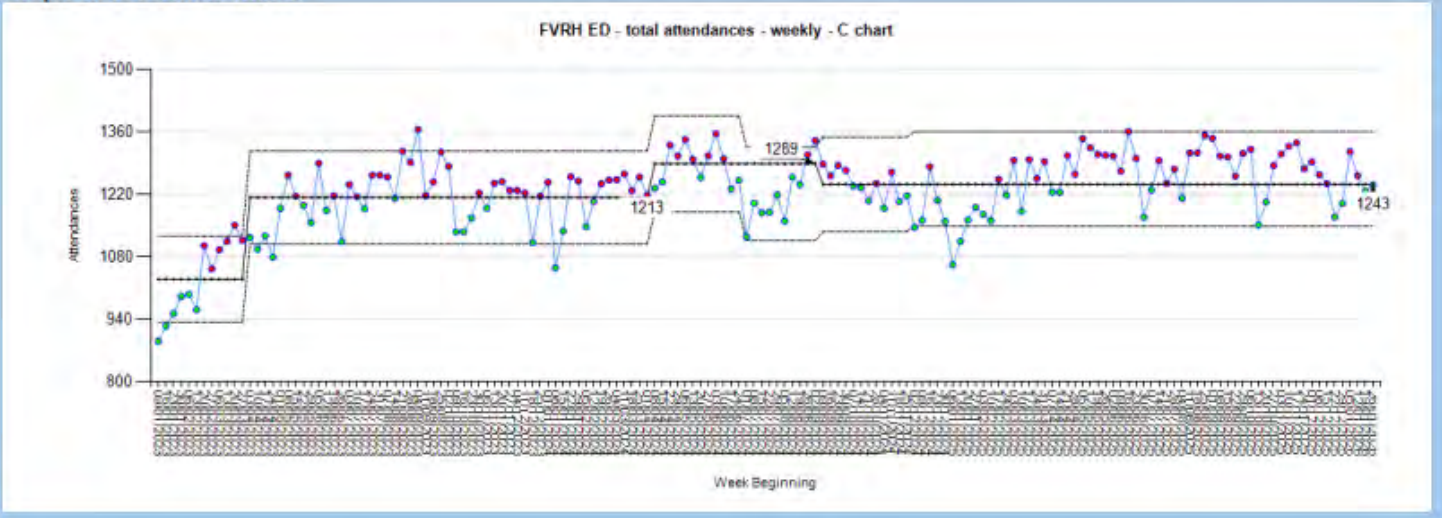
Graph 4.1: ED Occupancy at 8am



Our discovery data shows that ED occupancy at 8am has a statistically significant (negative) correlation with ED performance.

ED occupancy at 8am has increased notably during January, signalling renewed pressure on acute flow and a reversal of the improvements achieved immediately following CtR implementation. While the current process mean remains around **97.3%,** a high proportion of recent data points now sit above this mean, indicating that we are not currently on track to achieve the **≤95% trajectory for March 2026.** However, performance remains markedly improved compared to the same period last year, when occupancy was consistently well above current levels.

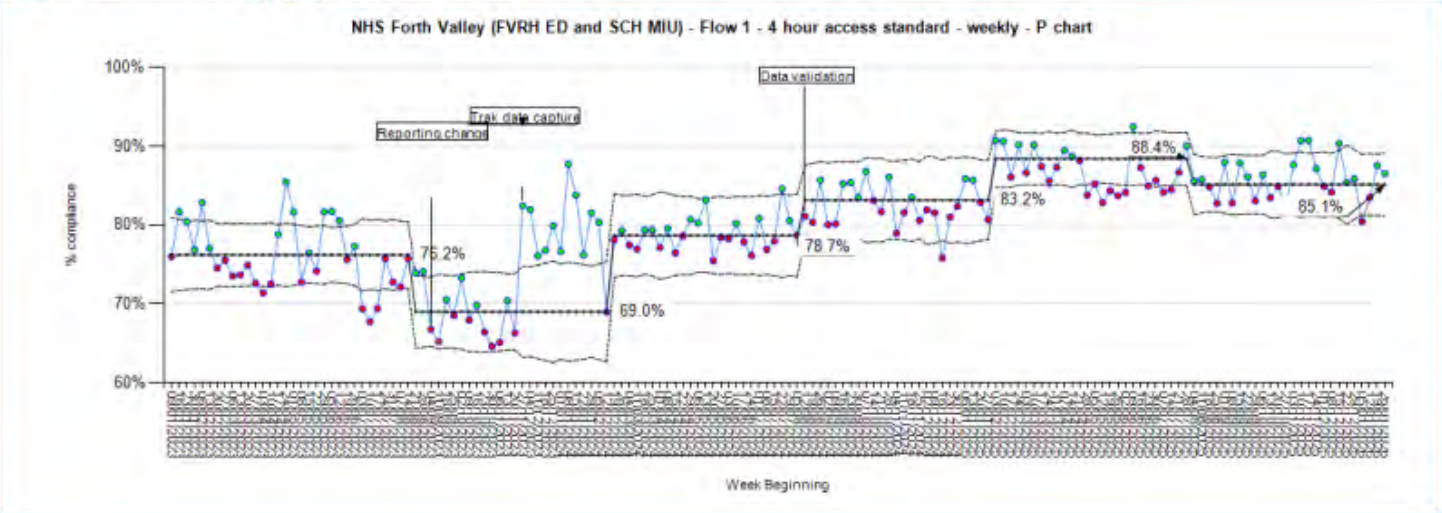
Graph 4.2: ED Attendances



Emergency Department attendances increased in January to 5,596, up from 5,455 in December.

4. Front Door Workstream (continued)

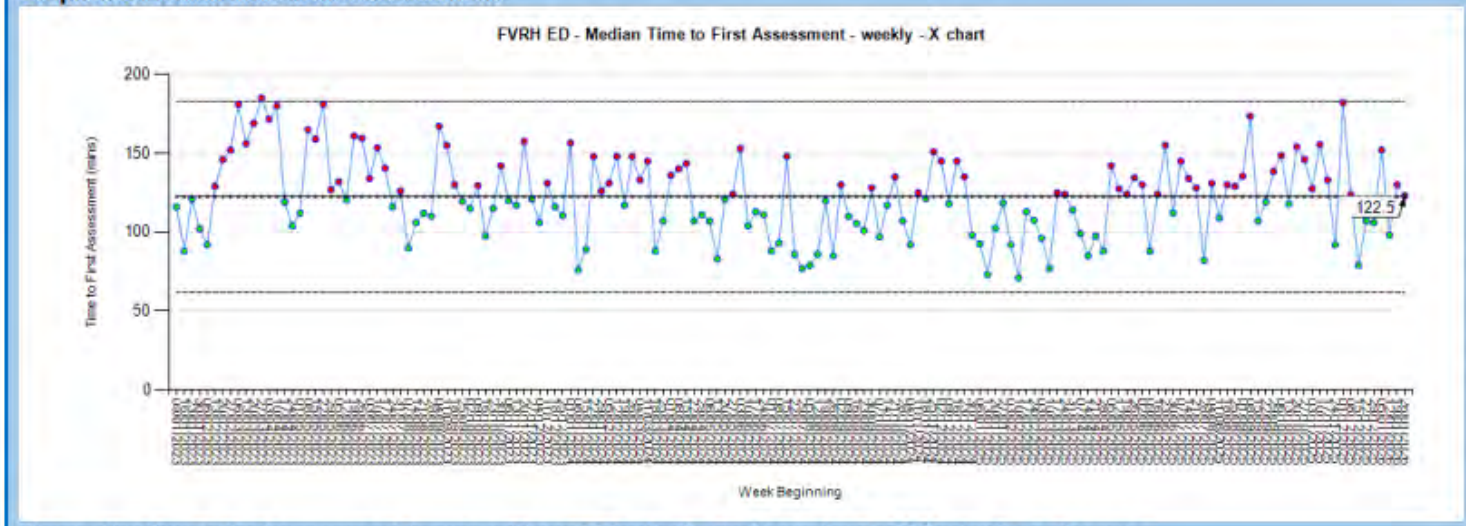
Graph 4.3: Flow 1 Emergency Access Standard



Flow 1 performance against the 4-hour standard declined slightly, falling from **86.5%** in December, to **84.1%** in January.

High utilisation of the Minor Injury Unit has a positive impact on our 4-hour performance and work to increase the number of patients on this pathway continues.

Graph 4.4: Median time to first assessment



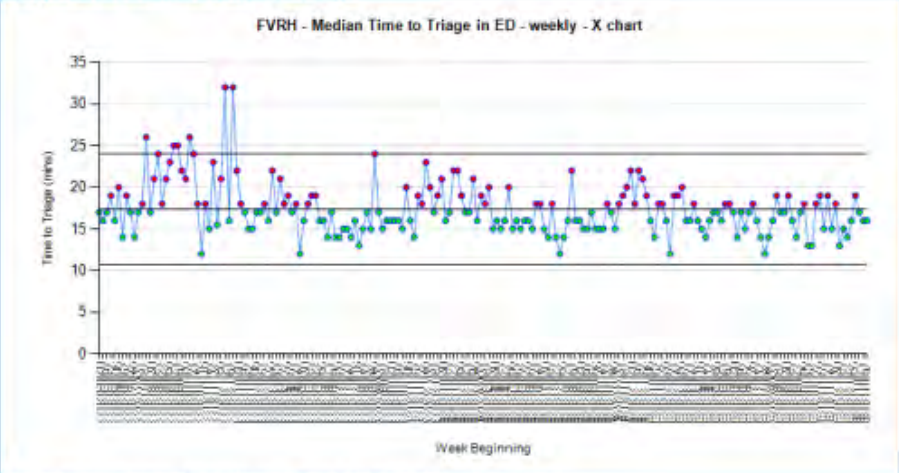
The median time to first assessment increased from **111 minutes** in December to **123 minutes** in January.

Our Discovery data showed that ED occupancy exceeds physical capacity in the afternoon, and each hour the ED is over occupancy is associated with a growing backlog of activity increasing time to first assessment, and a rise in ED length of stay.

The limited capacity of SCDMs within the ED overnight sees the day shift inherit a backlog of work from the overnight period which is associated with deteriorating performance outwith the 9am-5pm period.

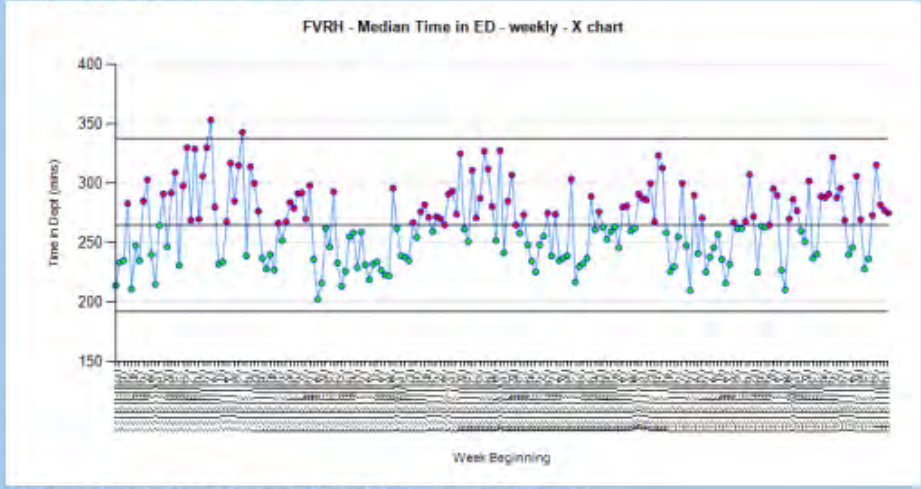
4. Front Door Workstream (continued)

Graph 4.5: Median time to triage



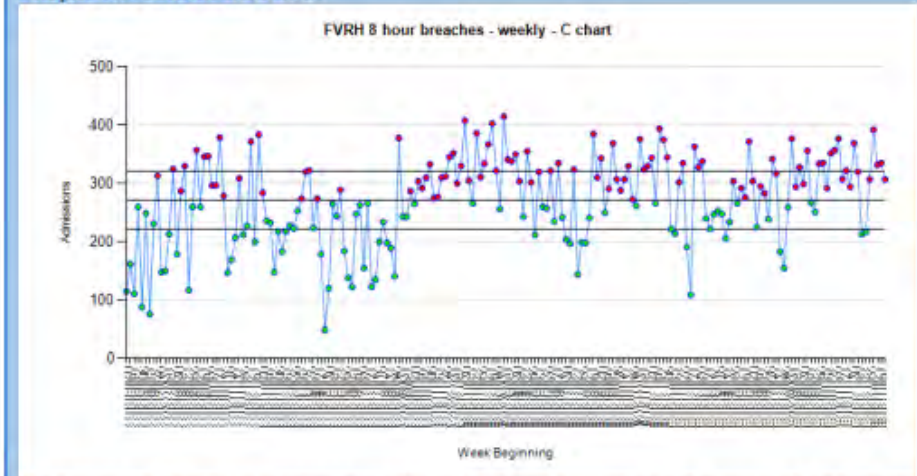
Median time to triage was **17 minutes** during January.

Graph 4.6: Median time in the ED

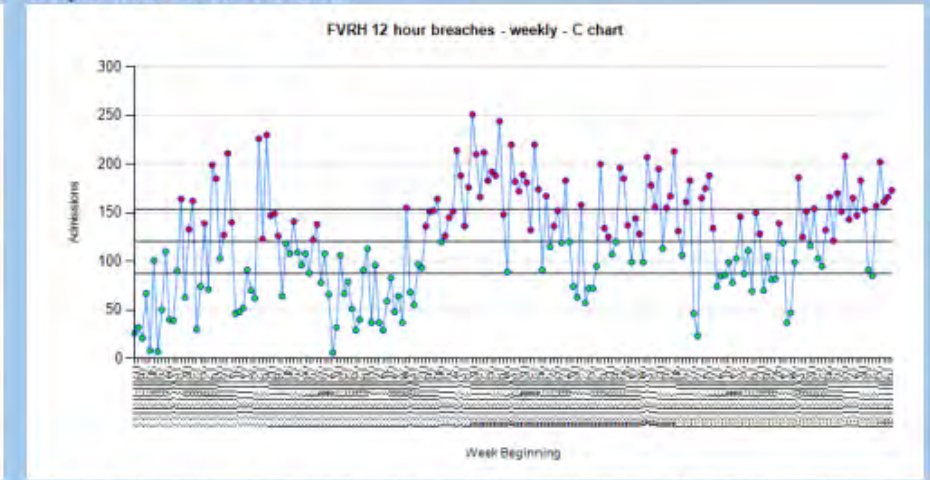


Median time in the ED was **286 minutes** during January.

Graph 4.7: 8-hour breaches



Graph 4.8: 12-hour breaches



The number of patients waiting over 8 and 12 hours remains high, suggesting that patients are staying longer due to delays in admission or discharge. Regular breach analysis would help pinpoint why patients are breaching the 4-hour target (e.g. delays in specialty review, diagnostics, bed availability) and highlight bottlenecks in the patient journey.

4. Front Door Workstream (continued)

Key constraints:

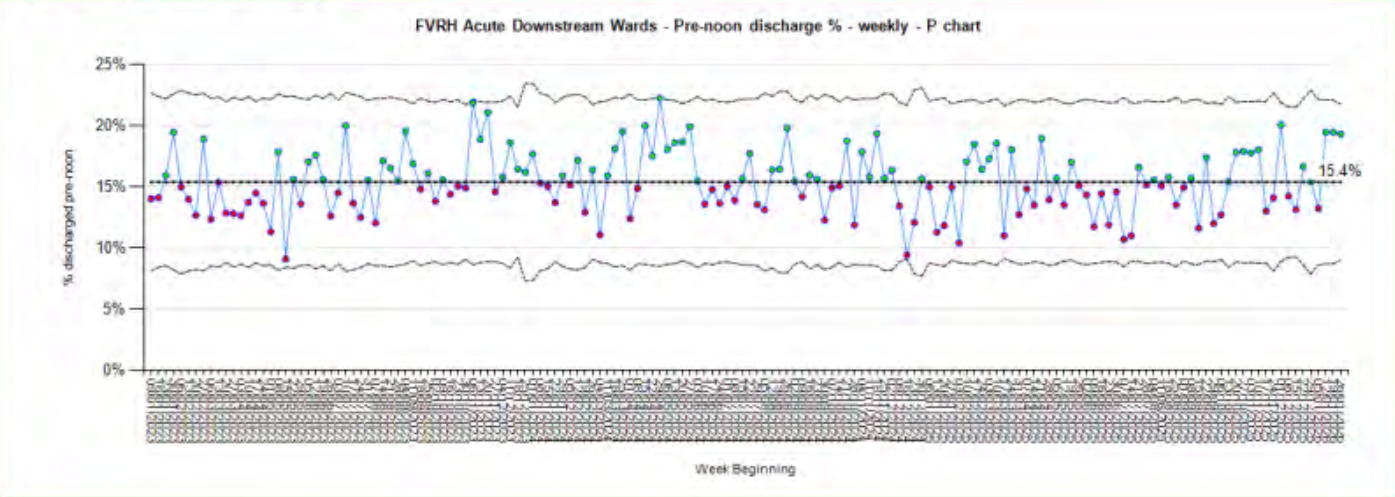
- ED occupancy at 8am has a statistically significant (negative) correlation with ED performance.
- Lack of real-time breach analysis limits our ability to identify root causes of 4-hour standard breaches, respond proactively, and implement targeted interventions to improve ED performance.
- Limited capacity of SCDMs within the ED overnight.
- We are not currently capturing data on redirection outcomes or the use of out-of-hospital care alternatives (Flow 5), which limits our ability to evaluate the effectiveness of diversion pathways and understand their impact on hospital attendances and admissions.
- Limited services (or in-reach to front door areas) to prevent admission and support care back into community services.

Next Steps:

- A focused 12-week improvement plan to address the ongoing and fluctuating pressures on Emergency Department attendances and improve patient flow. This plan will implement targeted actions (such as real-time breach analysis, rapid escalation protocols, and enhanced discharge processes) to deliver measurable improvements in ED performance and patient experience.
- CfSD to support an ED workforce benchmarking exercise to look at patient numbers, staffing ratios and 4-hour compliance.
- Flow 5 and redirection data – scoping how other boards capture this data / linked with our eHealth team to support.
- Redesign CAU triage to improve patient flow, clinical outcomes, and operational efficiency.
- Specialty zoning in the Acute Assessment Unit to support efficient patient flow, targeted clinical care, and safer working environments.

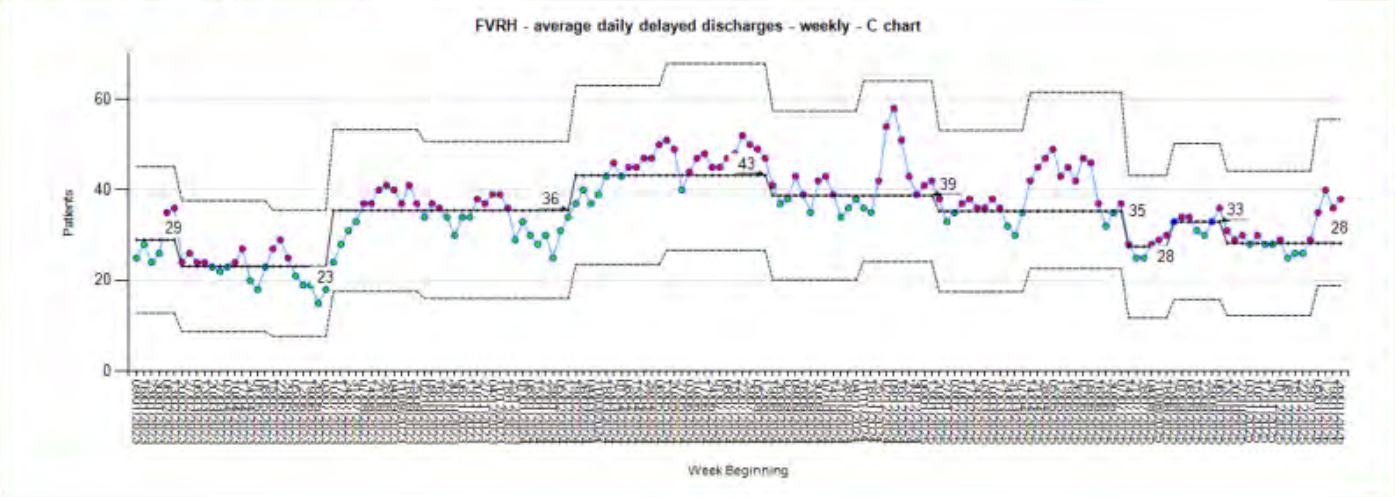
5. Discharge Without Delay Workstream

Graph 5.1: Pre-noon discharge



In January, the proportion of discharges completed before noon increased to **17.7%,** up from **15%** in December. The current target is **20%.**

Graph 5.2: FVRH delayed discharges

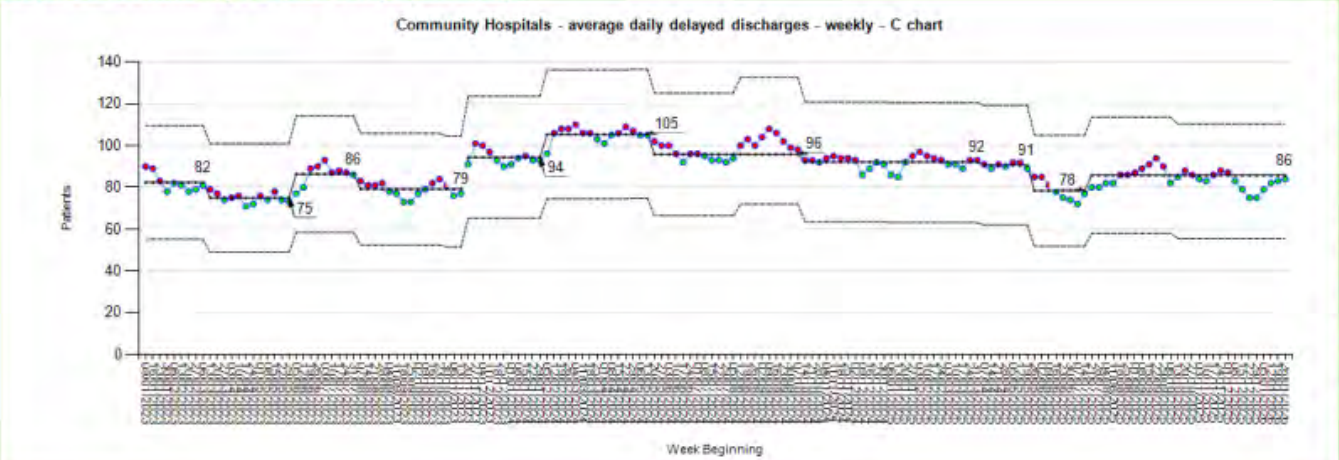


A sharp rise in delayed discharges was observed on the acute site during January. This reflects seasonal pressures following the festive period, including reduced community capacity, increased admissions, and a rise in longer-stay patients.

The mean average daily delayed discharges have reduced from a baseline of **33 to 28**, representing a **14.7% improvement**. While this reflects positive progress, performance remains below the **March 2026 target of a 25% reduction (approximately 25)**.

5. Discharge Without Delay (continued)

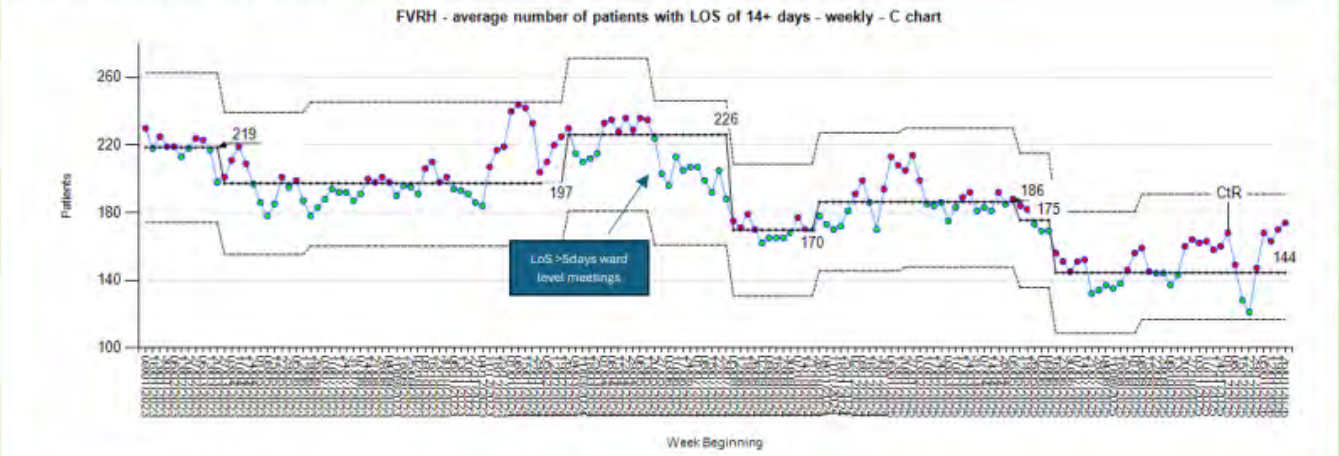
Graph 5.3: Community Hospital delayed discharges



While Community Hospitals have achieved a sustained reduction in delayed discharges, FVRH Community Waiting Lists remain elevated. This suggests that downstream capacity constraints continue to restrict the system's ability to convert discharge readiness into timely transfer.

A key objective of the National DWD Collaborative is to achieve a **20% reduction in Community Hospital delayed discharges, by March 2026.**

Graph 5.4: Length of Stay (LoS) >14 days

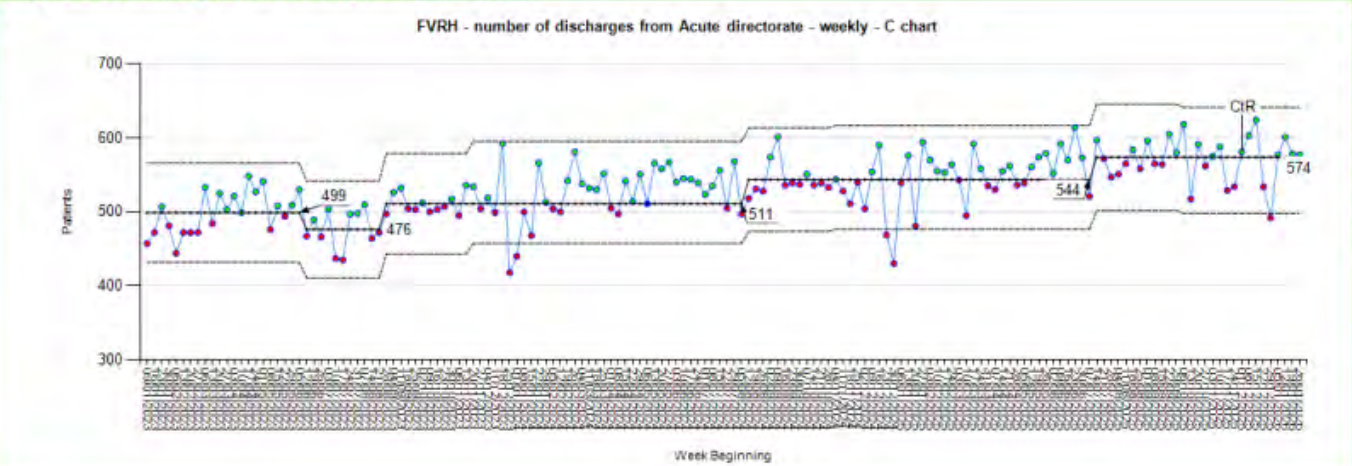


We have seen a sharp rise in LoS > 14 days during January, similar to the pattern observed at the same time last year. This seasonal increase is typically associated with higher winter acuity, reduced community capacity following the festive period, and slower discharge processes across both acute and downstream services.

LoS >14 days, which has a statistically significant correlation with ED performance.

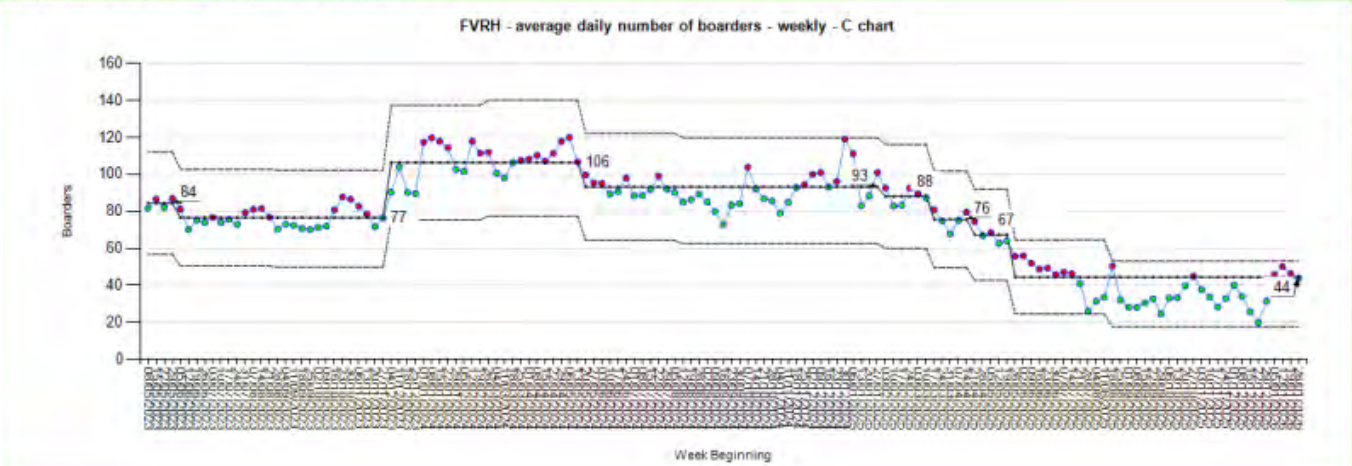
5. Discharge Without Delay Workstream (continued)

Graph 5.5: Discharges from FVRH acute directorate



We have seen an increase in the number of discharges following a dip over the Christmas and New Year period. We have returned to consistent application of Criteria to Reside to support discharge planning across the site, and five ward-based Discharge Coordinators are now in post.

Graph 5.6: Patients boarded to other areas

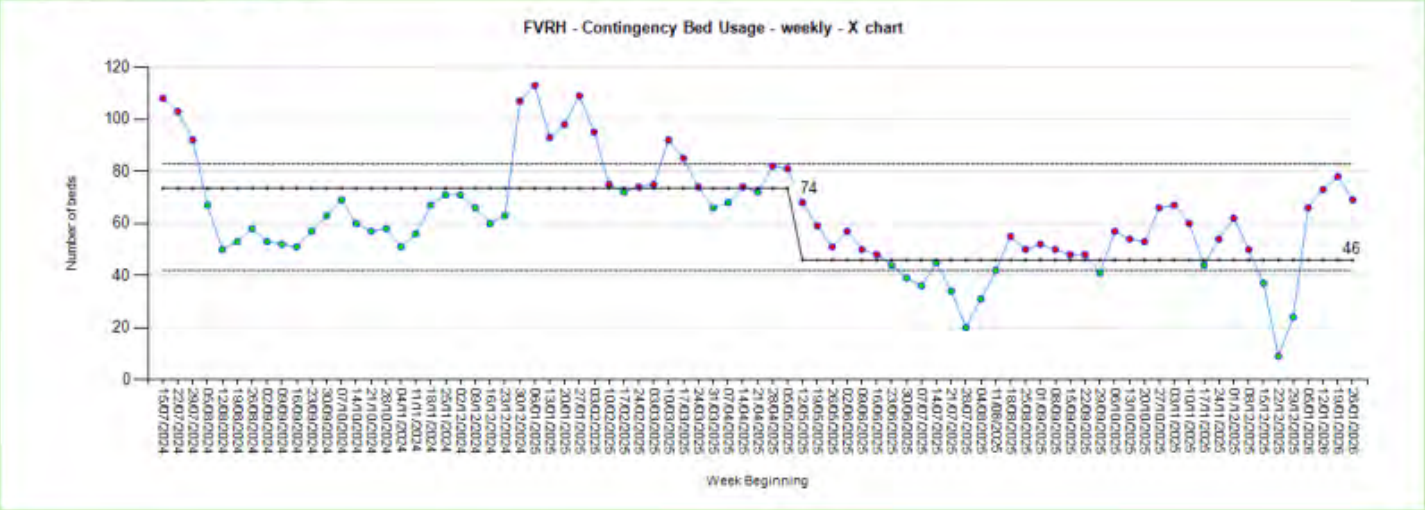


We have seen an increase in the number of boarders during January, reflecting rising site pressures and constrained bed availability across the hospital.

The average daily number of boarders has fallen significantly, with the mean rebased from **67 to 44**, representing a **58%** reduction from earlier peaks.

5. Discharge Without Delay Workstream (continued)

Graph 5.7: Contingency beds



We have also seen an increase in the use of contingency beds during January, reflecting rising site pressures and reduced flexibility within the core bed base.

Key constraints:

- High number of patients who do not meet Day of Care Survey (DoCS) criteria for an acute hospital stay.
- High number of patients with a length of stay >14 days as this has a statistically significant (negative) correlation with ED performance.
- Our current Integrated Discharge Service model does not support pathway-based discharge teams (ward-based).
- Access to Discharge to Assess pathways and Community Hospital stepdown beds.

Next steps

To accelerate progress on delayed discharges and patient flow, NHS Forth Valley will implement a focused ward-level improvement plan under the Discharge Without Delay (DWD) programme. This plan will strengthen daily discharge planning, embed predicted date of discharge (PDD) setting, and appoint ward-based discharge coordinators. Enhanced use of the Discharge Lounge and targeted dashboards will support timely patient movement and enable wards to monitor key metrics. These actions aim to sustain recent gains, adapt to fluctuating demand, and deliver person-centred care across all acute wards.

Section 3: Performance Report - Priority Areas of Performance

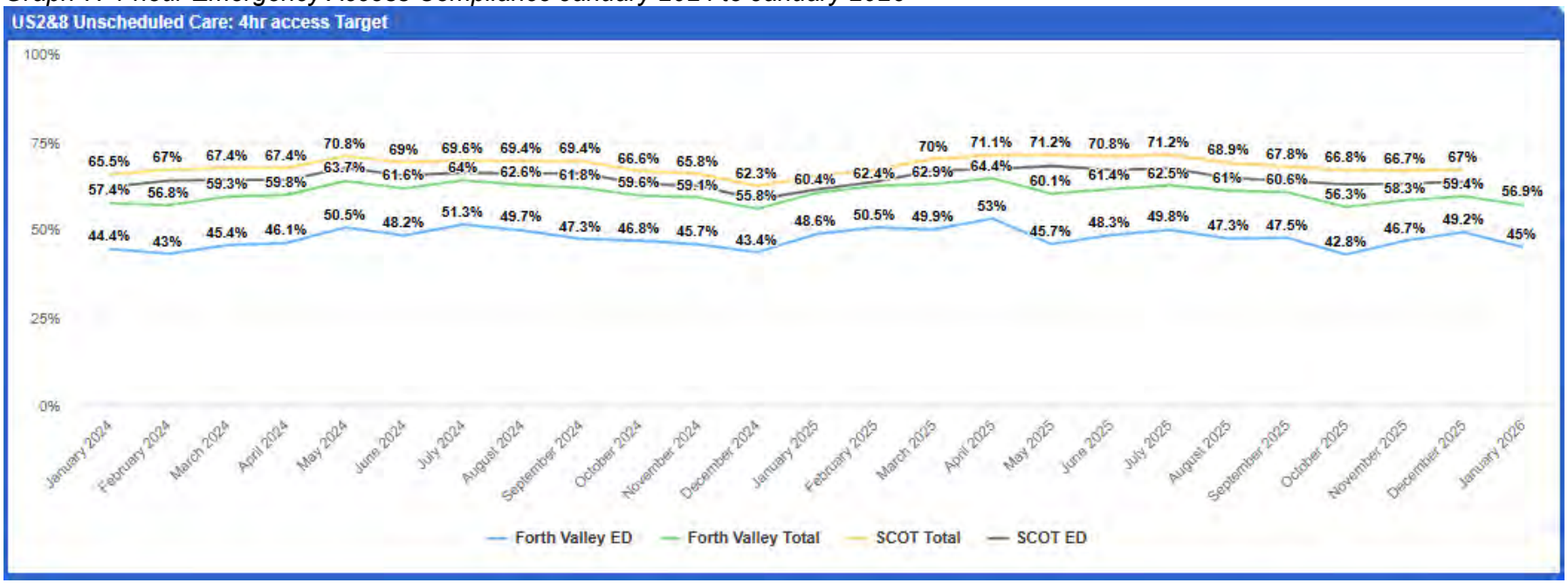
Unscheduled Care

4-hour Access Standard

Percentage of patients waiting less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment - 95% standard.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Emergency Department % compliance against 4 hour access target	31-Jan-26	95%	45.0%	49.2%	46.4%	▼	63.5%	31-Dec-25
Monthly	NHS Forth Valley Overall % compliance against 4 hour target	31-Jan-26	95%	56.9%	59.4%	53.6%	▲	67.0%	31-Dec-25

Graph 7: 4-hour Emergency Access Compliance January 2024 to January 2026

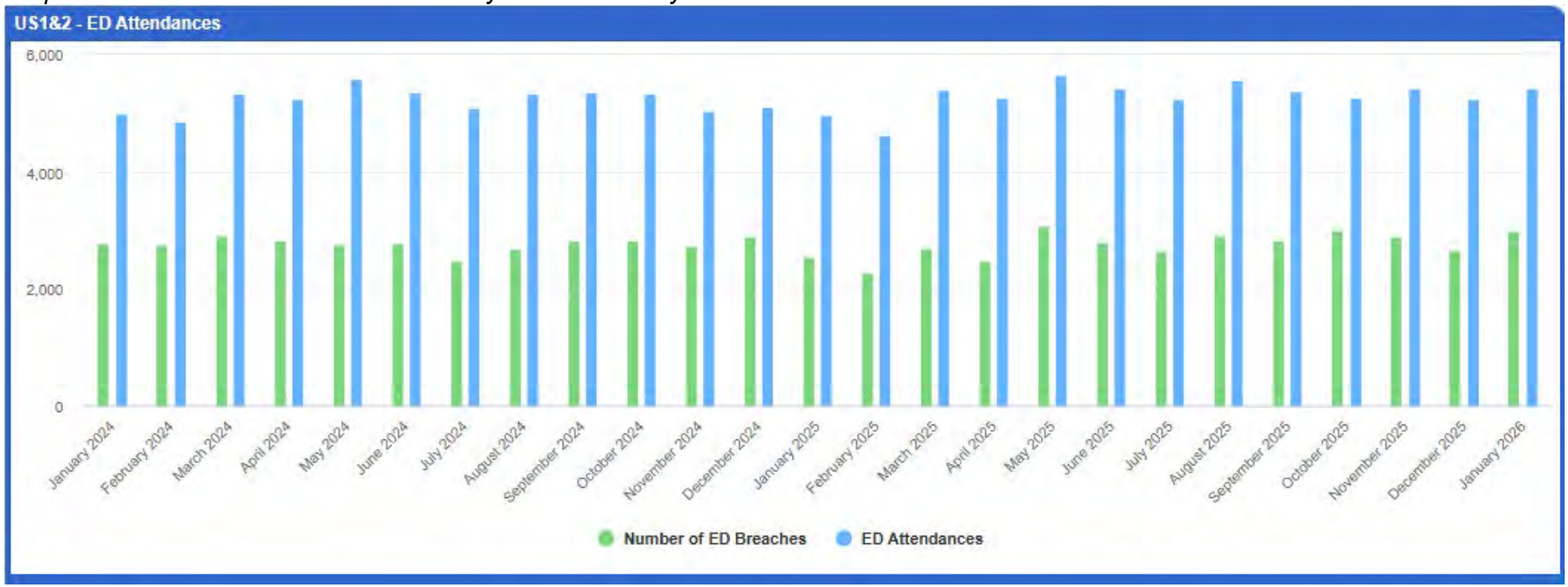


Overall compliance with the 4-hour emergency access standard (EAS) in January 2026 was 56.9%; Minor Injuries Unit 99.9%, Emergency Department 45%. A total of 2,985 patients waited longer than the 4-hour target across both the ED and Minor Injuries Unit (MIU); with 1,526 waits longer than eight hours, 784 waits longer than 12 hours and 150 waits longer than 23 hours.

Emergency Department

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total Number of ED Attendances	31-Jan-26	Reduction	5,424	5,238	4,966	▼	-	-
Monthly	Number that waited >4 hours in ED	31-Jan-26	Reduction	2,985	2,663	2,537	▼	-	-

Graph 8: Number of ED Attendances January 2024 to January 2026



The main reason for patients waiting beyond 4 hours continues to be wait for first assessment with a cohort of 1,866 patients, noting this was 1,311 in January 2025. Wait for a bed accounted for 647 patients waiting beyond 4 hours with Clinical reasons accounting for 127 breaches. It is worth noting 915 of patients attending ED in January 2026 did not wait.

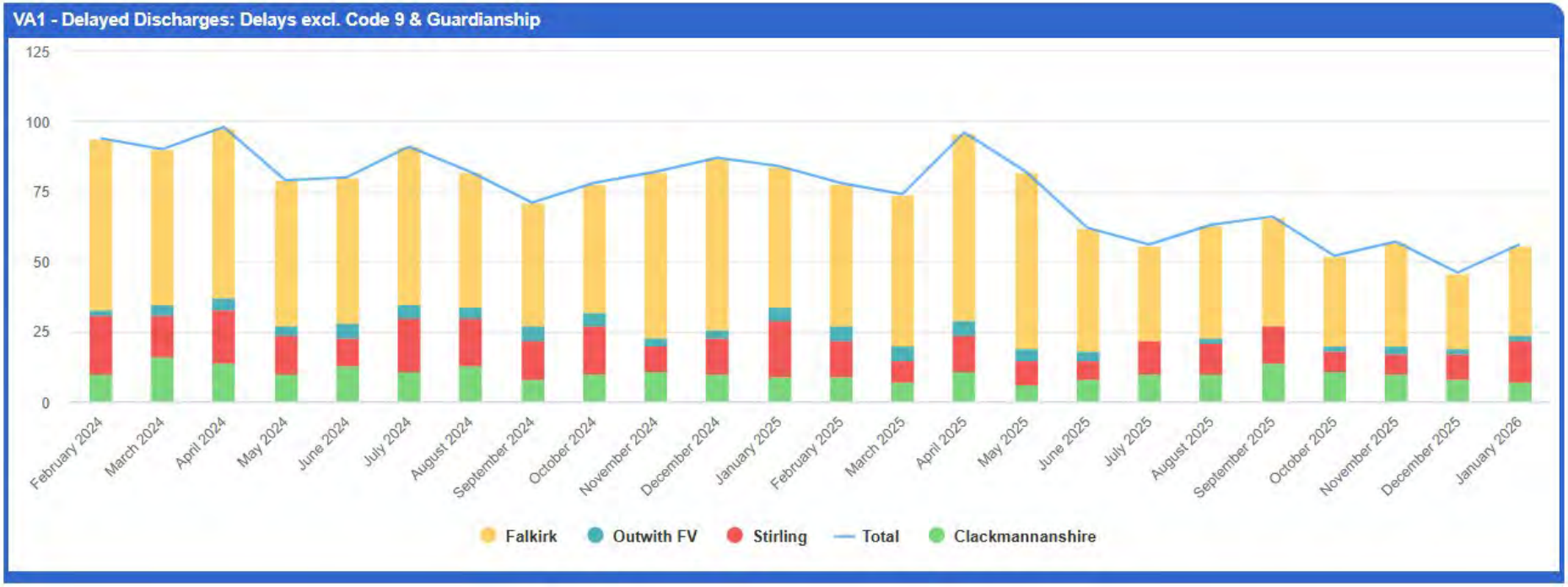
Work continues to support delivery of actions aligned to the various workstreams and projects underway system wide to support ongoing improvements in performance. In addition, NHS Forth Valley has joined the Discharge without Delay Collaborative which will influence the structure of how we align the ongoing actions in, and reporting through, one consolidated Urgent and Unscheduled Care/Delayed Discharge plan.

The Discharge without Delay programme underpins the work already underway in Forth Valley and focusses on four integrated delivery workstreams: Planned Date of Discharge and Integrated Discharge Hubs; Discharge to assess / Home First; Frailty at the Front Door; Community Hospital and Step-Down Rehabilitation Units. The aim is to improve the patient and staff experience, building towards better performance and flow through the hospital. This in turn will reduce patient length of stay and support a reduction in the financial burden.

Delayed Discharge

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	31-Jan-26	Reduction	54	46	84	▲	-	-
Monthly	Code 9 & Guardianship Delays	31-Jan-26	Reduction	57	56	44	▼	-	-
Monthly	Total Bed Days Occupied by Delayed Discharges (Standard Delays)	31-Jan-26	Reduction	1,644	1,744	2,097	▲	-	-

Graph 9: Number of standard delays – December 2023 to November 2025



The January 2026 census position in relation to standard delays (excluding Code 9 and guardianship) is 56 delays; this is compared to 84 in January 2025.

The number of bed days occupied by delayed discharges (excluding code 9 and 100) at the January 2026 census was 1,644, this is a reduction from 2,097 in January 2025. Local authority breakdown is noted as Clackmannanshire 181, Falkirk 1,073, Stirling 352. In addition, there were 38 bed days occupied by delayed discharges for local authorities' out with Forth Valley.

The issue of delayed discharges aligned to urgent & unscheduled care and system flow, is receiving considerable daily focus by the respective HSCP Chief Officers and their teams, jointly with the Acute hospital site, with weekly meetings in place. There is a continued focus on refining processes across our whole system discharge and flow activity. This includes process improvements around assessment and for adults with incapacity. Colleagues are visiting other board areas to learn from what is working well elsewhere and developing tests of change locally.

It should be noted that delayed discharges across Scotland are a particular focus of attention at Scottish Government and COSLA.

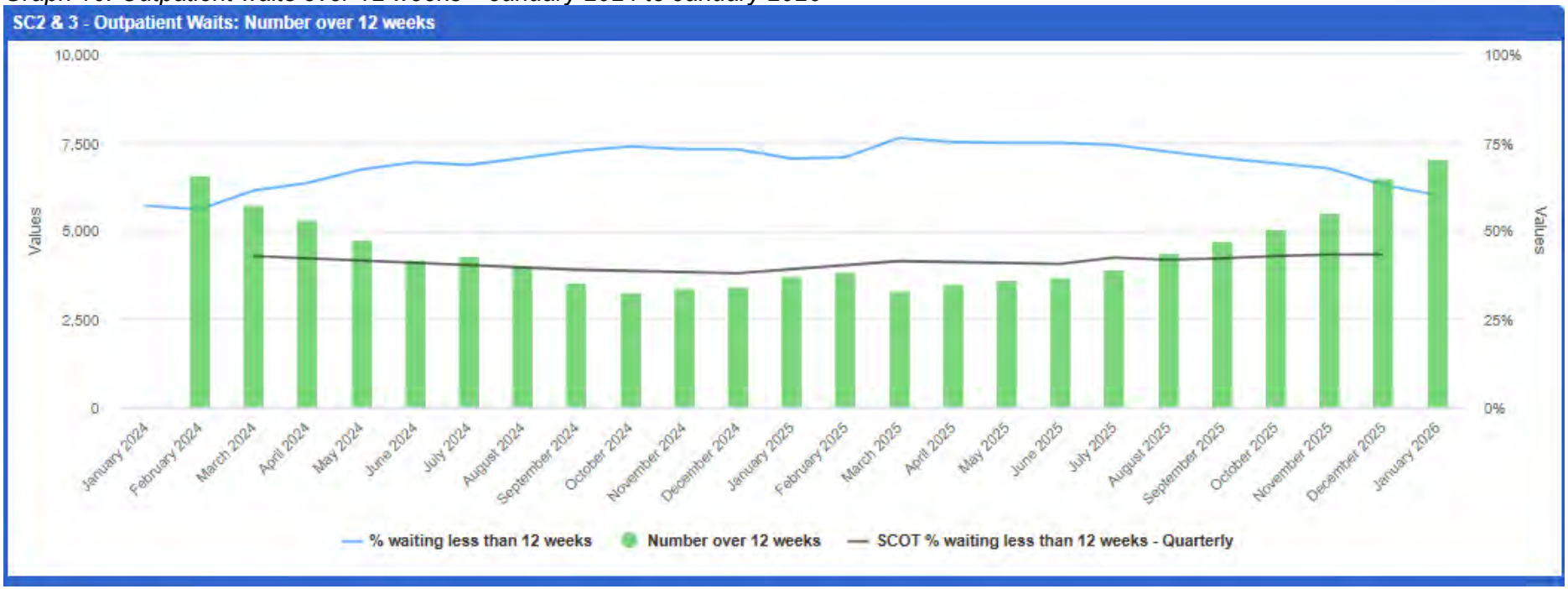
Scheduled Care

Outpatients

The percentage of patients waiting less than 12 weeks from referral to a first outpatient appointment – 95% Target.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total Number of New Outpatients Waiting	31-Jan-26	Reduction	17,599	17,544	12,661	▼	-	-
Monthly	Number of New Outpatients waiting over 12 weeks	31-Jan-26	Reduction	7,023	6,487	3,738	▼	-	-
Monthly	Number of New Outpatients waiting over 52 weeks	31-Jan-26	0	209	276	160	▼	-	-
Monthly	New Outpatients waiting under 12 weeks %	31-Jan-26	95%	60.1%	63.0%	70.5%	▼	43.2%	31-Dec-25

Graph 10: Outpatient waits over 12 weeks – January 2024 to January 2026



NHS Forth Valley concurrently treat patients that require urgent clinical care as well as those waiting for long periods, in line with associated Scottish Government guidance and targets.

At the end of January 2026, the number of patients on the waiting list for a first outpatient appointment was 17,599 (17.074 excluding mutual aid) compared with 12,661 in January 2025 with the number waiting beyond 12 weeks 7,023 (6,730 excluding mutual aid) compared to 3,738 in January 2025. Note 60.1% (60.6% excluding mutual aid) of patients were waiting less than 12 weeks for a first appointment; a decline in performance from 70.5% the same period the previous year.

The Scottish Government target for 2025/26 that 0 patients waiting over 52 weeks for a New Outpatient appointment. The graph and table below show the numbers and breakdown by specialty. Most specialties have no waits over 52 weeks and those that do are minimal.

The Scottish Government published updated waiting times guidance on 4 December 2023. The guidance aims to ensure consistency in how waiting lists are managed and to this end includes revisions to the ways in which adjustments can be made in relation to clock pauses and resets.

The 2023 Waiting Times Guidance revisions require changes to local patient management systems and the national waiting times data mart which is managed by Public Health Scotland.

Public Health Scotland data publications are now consistent with the 2023 guidance.

As NHS Forth Valley is progressing with implementation of the 2023 guidance in our patient management system, we are currently still accessing waiting times data based on calculations compliant with previous guidance. Resulting in differences in waiting times data provided from local system by NHS Forth Valley in comparison to data provided by Public Health Scotland in the interim period.

Graph 11: Number waiting over 52 weeks for new outpatient appointment - January 2024 to January 2026

Table 1: Number waiting over 52 weeks for New Outpatient appointment by Specialty – January 2026

Planned Care - New outpatient >52 Week waits

LG Service Area	Value	Numerator	Denominator
Respiratory Medicine	9.1%	56	617
Dermatology	1.5%	50	3,444
General Surgery - Plastics	12.8%	46	358
Urology	2.2%	17	773
Rehabilitation Medicine	100.0%	8	8

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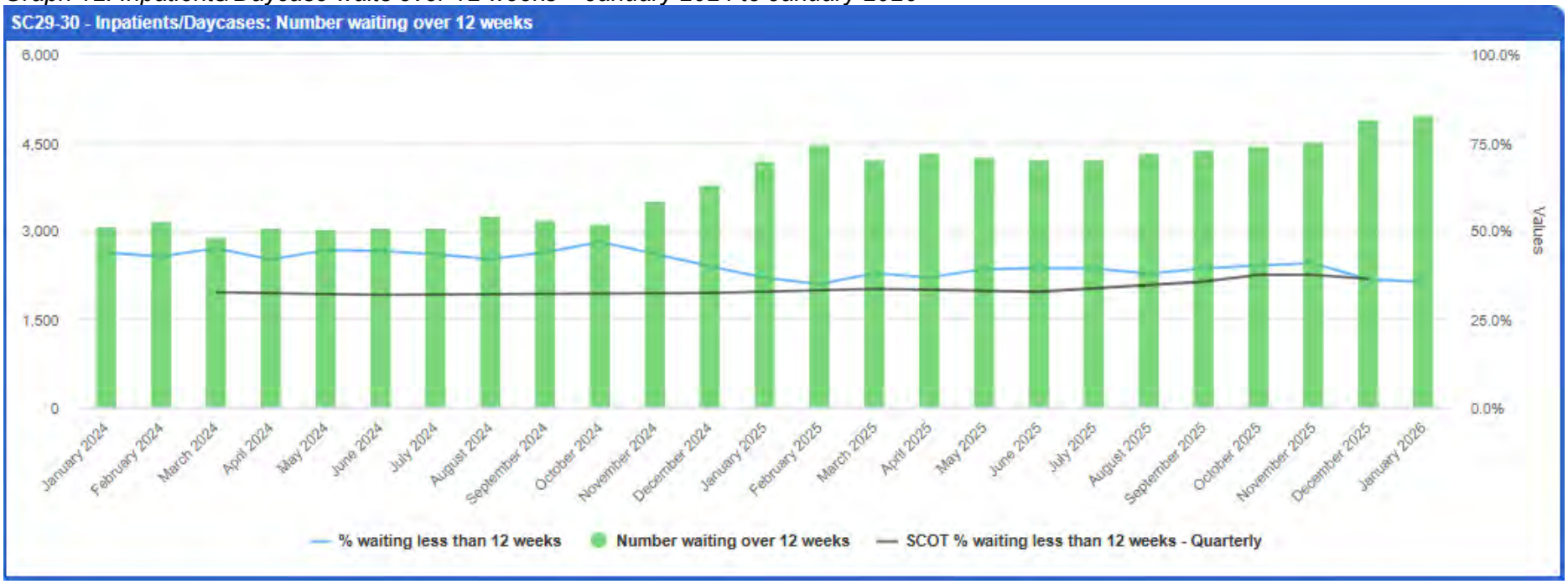
Inpatients

Treatment Time Guarantee (TTG) - Eligible patients who start to receive their day case or inpatient treatment within 12 weeks of the agreement to treat – 100% Target.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Quarterly	Number of patients that waited >12 weeks - Completed Wait	31-Dec-25	0	1,847	2,054	1,386	-	-	-
Quarterly	% Compliance with 12 week TTG Standard	31-Dec-25	100%	35.4%	33.6%	44.6%	▼	57.9%	31-Dec-25
Monthly	Total Number of Inpatients/Day cases Waiting	31-Jan-26	Reduction	7,730	7,672	6,616	▼	-	-
Monthly	Number of Inpatients/Day cases waiting over 12 weeks	31-Jan-26	Reduction	4,982	4,895	4,189	▼	-	-
Monthly	Number of Inpatients/Day cases waiting over 52 weeks	31-Jan-26	0%	362	443	554	▲	-	-
Monthly	Percentage of Inpatients/Day cases waiting under 12 weeks	31-Jan-26	100%	35.5%	36.2%	36.7%	▼	36.4%	31-Dec-25

Graph 12: Inpatients/Daycase waits over 12 weeks – January 2024 to January 2026



In January 2026, the number of inpatients/daycases waiting increased to 7,730 (7,457 excluding mutual aid and NTC) from 7,672 (7,329 excluding mutual aid and NTC) the previous month. An increase from the previous year in those waiting beyond 12 weeks from 4,189 to 4,982 was also noted.

The aim for 2025/26 is that there will be no patients waiting beyond 52 weeks for Inpatient / Daycase treatment. Graph 15 and table 2 below show the numbers and breakdown by specialty respectively as at end of May. Weekly monitoring of the specialties with the largest numbers waiting over 12 weeks would suggest, based on progress so far, that we are on track to meet the target for end of March 2026. Details are included in the specialty sections below.

Graph 13: Number waiting over 52 weeks for Inpatient/Daycase – January 2024 to January 2026

Table 2: Number waiting over 52 weeks for Inpatient/Daycase by Specialty – January 2026

Planned Care - TTG >52 Week waits

LG Service Area	Value	Numerator	Denominator
Trauma and Orthopaedic Surgery	5.3%	141	2,656
Ear, Nose and Throat (ENT)	10.9%	93	855
General Surgery	5.8%	50	859
Urology	11.3%	49	432
Gynaecology	2.9%	16	543
Vascular Surgery	11.0%	9	82
Pain Management	7.3%	3	41
Ophthalmology	.0%	1	2,028

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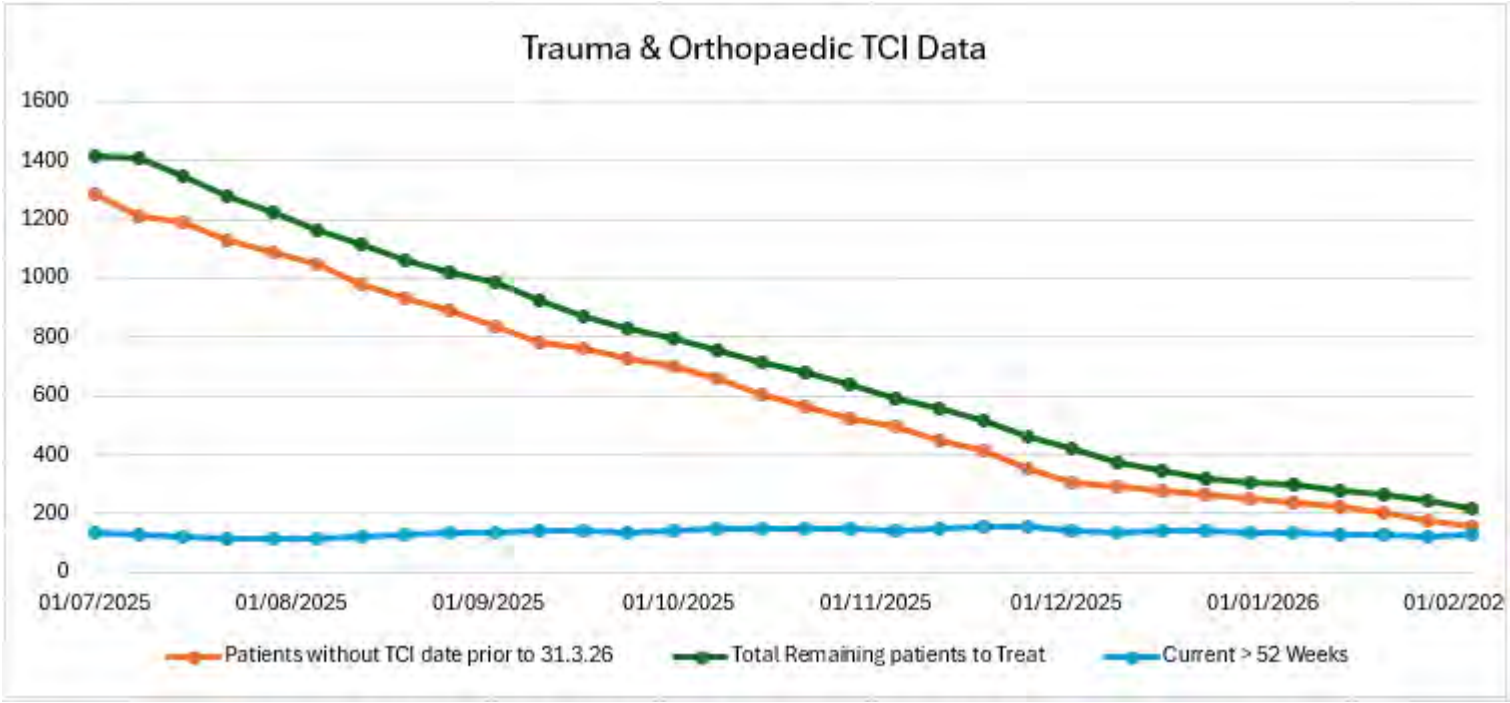
The following specialty level sections detail the weekly position of the waiting lists with the largest numbers waiting over 52 weeks, these show the numbers waiting in total and the numbers dated To Come In (TCI). Further breakdowns show the numbers waiting over 52 weeks and the numbers and percentages of these which are dated to come in and of which are currently unavailable.

Trauma and Orthopaedic Surgery

Table 3: Trauma and Orthopaedic clearance of IPDC >52-week waiters

		Included: Trauma and Orthopaedic Surgery Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.2	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Weeks	Current > 78 Weeks	Longest Wait (weeks)	No > 52 Weeks Dated	No > 52 Weeks Unavailable	% of 52 Weeks Dated	% of 52 Weeks Unavailable
01/07/2025	Trauma and Orthopaedic Surgery	131	1285	1416	133	17	100	27	32	20	24
08/07/2025	Trauma and Orthopaedic Surgery	195	1213	1408	128	18	100	26	31	20	24
15/07/2025	Trauma and Orthopaedic Surgery	158	1189	1347	123	17	95	18	28	14	22
22/07/2025	Trauma and Orthopaedic Surgery	147	1131	1278	118	11	96	22	27	18	22
29/07/2025	Trauma and Orthopaedic Surgery	140	1085	1225	115	10	95	17	22	14	19
05/08/2025	Trauma and Orthopaedic Surgery	113	1049	1162	113	10	96	19	23	16	20
12/08/2025	Trauma and Orthopaedic Surgery	140	978	1118	122	11	97	25	27	20	22
19/08/2025	Trauma and Orthopaedic Surgery	127	933	1060	131	9	98	21	21	16	16
26/08/2025	Trauma and Orthopaedic Surgery	135	888	1023	132	7	94	20	23	15	17
02/09/2025	Trauma and Orthopaedic Surgery	150	834	984	135	8	95	28	24	20	17
09/09/2025	Trauma and Orthopaedic Surgery	138	785	923	141	8	96	39	27	27	19
16/09/2025	Trauma and Orthopaedic Surgery	113	758	871	140	7	85	33	21	23	15
23/09/2025	Trauma and Orthopaedic Surgery	101	727	828	133	7	96	27	19	20	14
30/09/2025	Trauma and Orthopaedic Surgery	95	702	797	139	9	87	29	19	20	13
07/10/2025	Trauma and Orthopaedic Surgery	94	662	756	146	7	88	27	18	18	12
14/10/2025	Trauma and Orthopaedic Surgery	111	603	714	149	6	89	31	24	20	16
21/10/2025	Trauma and Orthopaedic Surgery	117	564	681	146	6	89	28	27	19	18
28/10/2025	Trauma and Orthopaedic Surgery	115	521	636	147	7	90	34	21	23	14
04/11/2025	Trauma and Orthopaedic Surgery	101	493	594	143	5	89	35	19	24	13
11/11/2025	Trauma and Orthopaedic Surgery	106	448	554	149	4	90	45	23	30	15
18/11/2025	Trauma and Orthopaedic Surgery	98	415	513	153	2	91	45	22	29	14
25/11/2025	Trauma and Orthopaedic Surgery	109	350	459	156	3	92	51	26	32	16
02/12/2025	Trauma and Orthopaedic Surgery	112	307	419	143	2	79	48	27	33	18
09/12/2025	Trauma and Orthopaedic Surgery	83	290	373	135	1	80	35	28	25	20
16/12/2025	Trauma and Orthopaedic Surgery	70	275	345	142	2	82	29	29	20	20
23/12/2025	Trauma and Orthopaedic Surgery	53	265	318	143	1	83	26	33	18	23
30/12/2025	Trauma and Orthopaedic Surgery	58	250	308	137	1	84	30	28	21	20
06/01/2026	Trauma and Orthopaedic Surgery	59	238	297	132	0	77	30	20	22	15
13/01/2026	Trauma and Orthopaedic Surgery	55	222	277	128	1	78	31	18	24	14
20/01/2026	Trauma and Orthopaedic Surgery	62	200	262	125	1	79	34	20	27	16
27/01/2026	Trauma and Orthopaedic Surgery	64	178	242	124	1	80	33	24	26	19
03/02/2026	Trauma and Orthopaedic Surgery	60	154	214	126	1	81	39	23	30	18

Graph 14: Trauma and Orthopaedic reduction of the target cohort

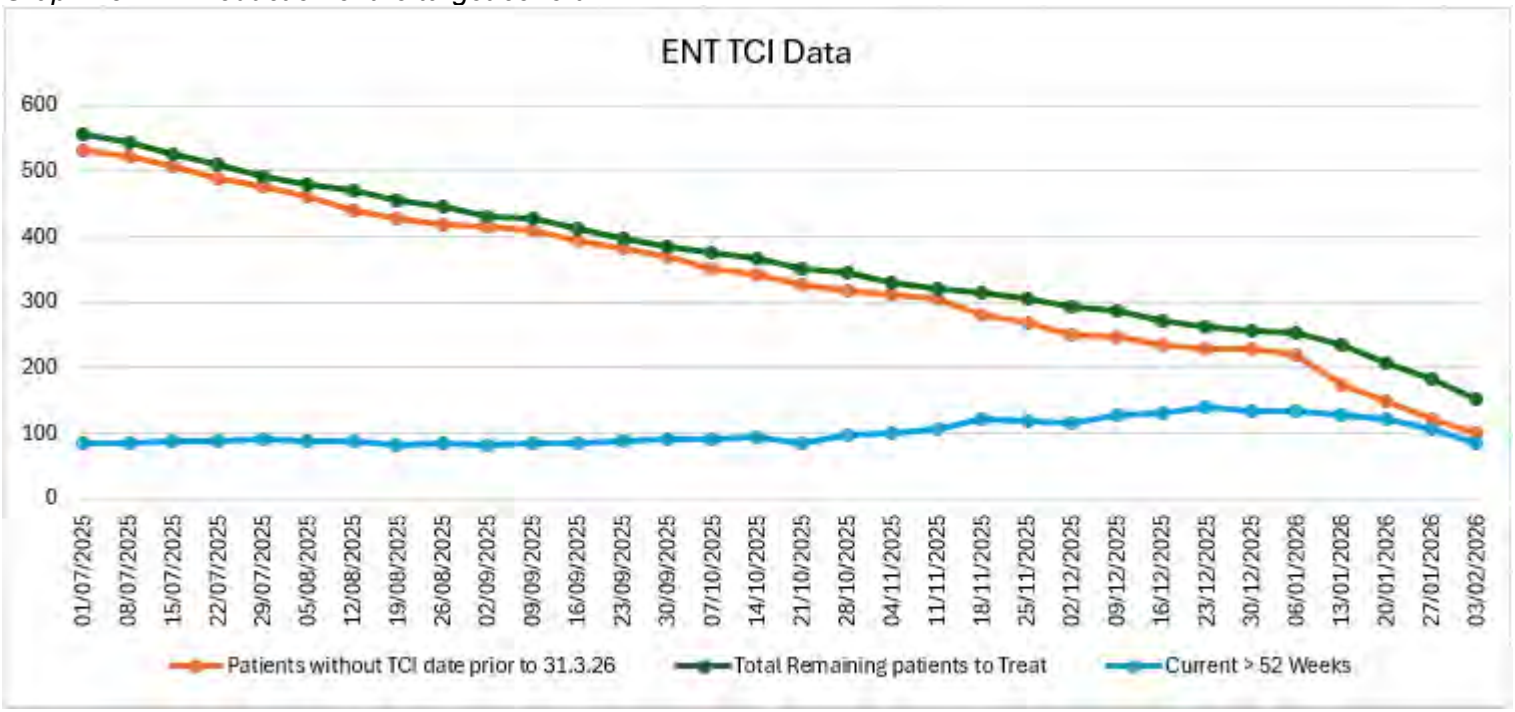


Ear, Nose and Throat

Table 4: ENT clearance of IPDC >52-week waiters

		Included: ENT Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Weeks	Current > 78 Weeks	Longest Wait (weeks)	No > 52 Weeks Dated	No > 52 Weeks Unavailable	% of 52 Weeks Dated	% of 52 Weeks Unavailable
01/07/2025	Ear, Nose and Throat (ENT)	25	532	557	84	15	97	6	16	7	19
08/07/2025	Ear, Nose and Throat (ENT)	21	522	543	86	18	94	5	15	5	17
15/07/2025	Ear, Nose and Throat (ENT)	19	507	526	87	16	95	3	12	3	13
22/07/2025	Ear, Nose and Throat (ENT)	22	488	510	88	16	96	11	11	12	12
29/07/2025	Ear, Nose and Throat (ENT)	16	477	493	92	16	91	10	10	10	10
05/08/2025	Ear, Nose and Throat (ENT)	18	461	479	87	15	92	9	11	10	12
12/08/2025	Ear, Nose and Throat (ENT)	29	441	470	89	13	91	18	6	20	6
19/08/2025	Ear, Nose and Throat (ENT)	27	428	455	82	14	92	11	5	13	6
26/08/2025	Ear, Nose and Throat (ENT)	27	419	446	85	14	93	11	6	12	7
02/09/2025	Ear, Nose and Throat (ENT)	14	417	431	83	13	94	8	5	9	6
09/09/2025	Ear, Nose and Throat (ENT)	20	408	428	86	13	95	12	7	13	8
16/09/2025	Ear, Nose and Throat (ENT)	19	394	413	86	12	96	9	8	10	9
23/09/2025	Ear, Nose and Throat (ENT)	14	382	396	87	10	97	7	10	8	11
30/09/2025	Ear, Nose and Throat (ENT)	17	369	386	91	10	98	10	10	10	10
07/10/2025	Ear, Nose and Throat (ENT)	25	351	376	90	11	96	16	8	17	8
14/10/2025	Ear, Nose and Throat (ENT)	25	342	367	94	9	94	12	11	12	11
21/10/2025	Ear, Nose and Throat (ENT)	24	328	352	86	5	95	13	11	15	12
28/10/2025	Ear, Nose and Throat (ENT)	25	319	344	96	8	96	17	13	17	13
04/11/2025	Ear, Nose and Throat (ENT)	19	311	330	100	6	97	12	10	12	10
11/11/2025	Ear, Nose and Throat (ENT)	17	305	322	105	6	98	8	12	7	11
18/11/2025	Ear, Nose and Throat (ENT)	33	282	315	121	7	99	27	12	22	9
25/11/2025	Ear, Nose and Throat (ENT)	36	269	305	119	6	100	31	10	26	8
02/12/2025	Ear, Nose and Throat (ENT)	43	250	293	115	7	101	36	9	31	7
09/12/2025	Ear, Nose and Throat (ENT)	39	247	286	128	6	102	34	10	26	7
16/12/2025	Ear, Nose and Throat (ENT)	37	236	273	130	6	103	33	11	25	8
23/12/2025	Ear, Nose and Throat (ENT)	32	230	262	139	6	104	32	12	23	8
30/12/2025	Ear, Nose and Throat (ENT)	29	228	257	134	6	105	27	9	20	6
06/01/2026	Ear, Nose and Throat (ENT)	31	221	252	134	7	106	30	7	22	5
13/01/2026	Ear, Nose and Throat (ENT)	62	174	236	129	5	102	60	5	46	3
20/01/2026	Ear, Nose and Throat (ENT)	59	148	207	121	4	102	54	6	44	4
27/01/2026	Ear, Nose and Throat (ENT)	64	120	184	105	2	95	51	9	48	8
03/02/2026	Ear, Nose and Throat (ENT)	53	99	152	84	0	75	41	11	48	13

Graph 15: ENT reduction of the target cohort

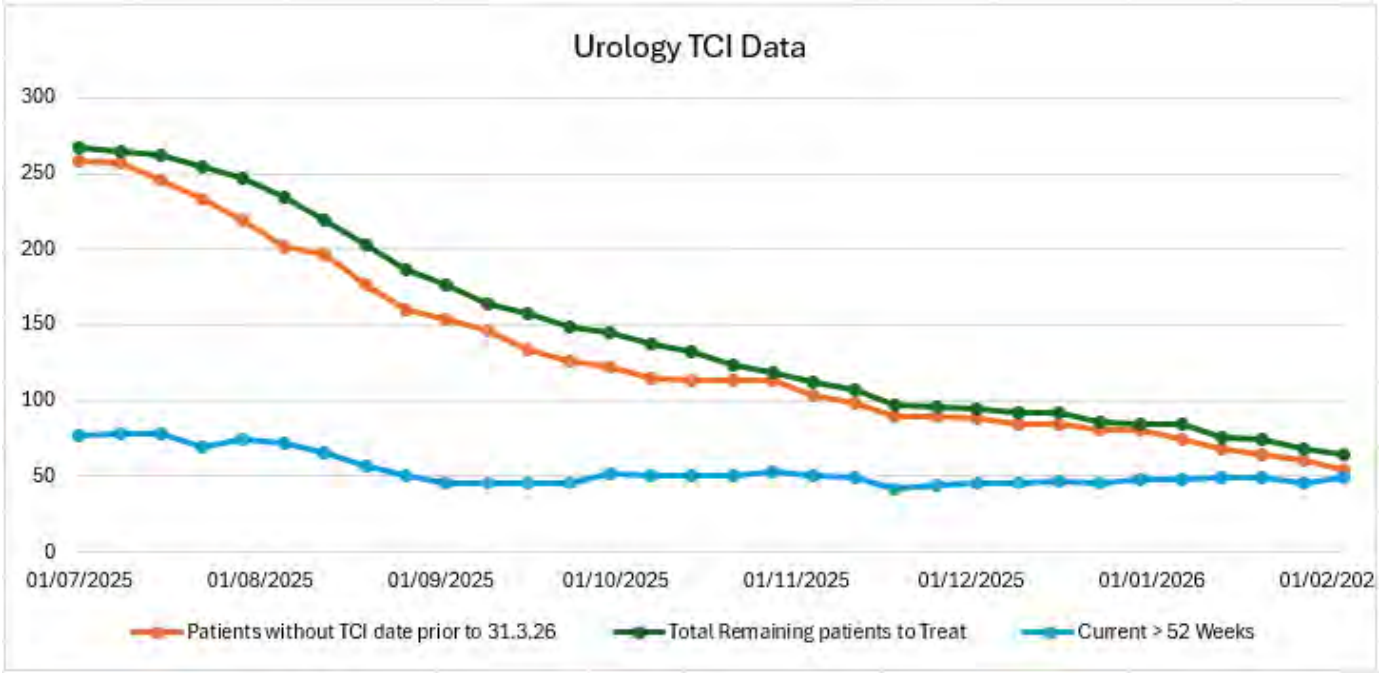


Urology

Table 5: Urology clearance of IPDC >52-week waiters

		Included: Urology Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Weeks	Current > 78 Weeks	Longest Wait (weeks)	No > 52 Weeks Dated	No > 52 Weeks Unavailable	% of 52 Weeks Dated	% of 52 Weeks Unavailable
01/07/2025	Urology	9	258	267	77	37	110	4	4	5	5
08/07/2025	Urology	7	257	264	78	38	111	5	5	6	6
15/07/2025	Urology	16	246	262	78	41	112	7	5	8	6
22/07/2025	Urology	21	233	254	70	38	113	7	6	10	8
29/07/2025	Urology	28	219	247	74	36	114	15	7	20	9
05/08/2025	Urology	33	201	234	72	36	115	24	8	33	11
12/08/2025	Urology	23	196	219	66	30	115	16	5	24	7
19/08/2025	Urology	26	177	203	57	23	116	12	4	21	7
26/08/2025	Urology	27	160	187	51	18	117	10	4	19	7
02/09/2025	Urology	23	154	177	46	17	118	6	4	13	8
09/09/2025	Urology	18	146	164	45	16	119	8	4	17	8
16/09/2025	Urology	23	134	157	46	16	120	8	1	17	2
23/09/2025	Urology	23	126	149	46	12	121	11	0	23	0
30/09/2025	Urology	23	122	145	52	12	122	13	1	25	1
07/10/2025	Urology	23	115	138	51	12	123	10	1	19	1
14/10/2025	Urology	18	114	132	51	12	124	8	2	15	3
21/10/2025	Urology	10	114	124	51	7	125	2	3	3	5
28/10/2025	Urology	4	114	118	53	5	122	1	4	1	7
04/11/2025	Urology	9	103	112	51	4	123	8	4	15	7
11/11/2025	Urology	9	98	107	49	3	87	7	2	14	4
18/11/2025	Urology	8	89	97	42	2	88	2	3	4	7
25/11/2025	Urology	6	90	96	44	2	89	0	4	0	9
02/12/2025	Urology	7	88	95	45	3	90	1	4	2	8
09/12/2025	Urology	8	84	92	46	2	82	3	3	6	6
16/12/2025	Urology	7	85	92	47	2	83	3	4	6	8
23/12/2025	Urology	5	81	86	46	1	84	5	3	10	6
30/12/2025	Urology	4	81	85	48	2	85	4	3	8	6
06/01/2026	Urology	10	74	84	48	1	86	10	2	20	4
13/01/2026	Urology	8	68	76	49	0	75	7	1	14	2
20/01/2026	Urology	10	65	75	49	0	76	9	1	18	2
27/01/2026	Urology	8	60	68	46	0	77	7	1	15	2
03/02/2026	Urology	11	54	65	49	1	78	10	4	20	8

Graph 16: Urology reduction of the target cohort

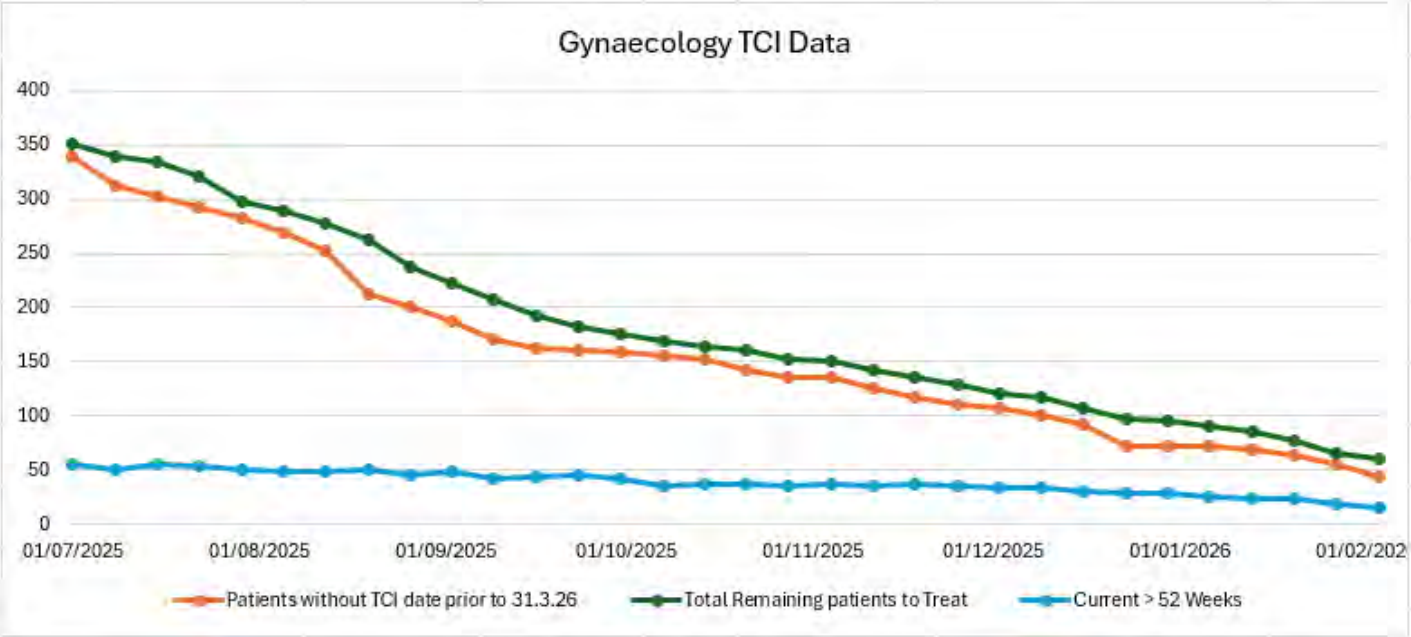


Gynaecology

Table 6: Gynaecology clearance of IPDC >52-week waiters

		Included: Gynaecology Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Week	Current > 78 Week	Longest Wait (weeks)	No > 52 Weeks Dated	No > 52 Weeks Unavailab	% of 52 Weeks Dated	% of 52 Weeks Unavailab
01/07/2025	Gynaecology	13	339	352	55	4	104	4	4	7	7
08/07/2025	Gynaecology	28	312	340	51	4	105	5	4	9	7
15/07/2025	Gynaecology	32	303	335	55	5	106	6	4	10	7
22/07/2025	Gynaecology	29	292	321	53	5	107	5	3	9	5
29/07/2025	Gynaecology	15	283	298	51	6	108	3	2	5	3
05/08/2025	Gynaecology	20	270	290	49	7	109	7	3	14	6
12/08/2025	Gynaecology	26	252	278	49	6	110	11	5	22	10
19/08/2025	Gynaecology	50	213	263	50	6	111	16	6	32	12
26/08/2025	Gynaecology	37	201	238	46	6	96	14	7	30	15
02/09/2025	Gynaecology	35	187	222	48	5	97	10	5	20	10
09/09/2025	Gynaecology	38	170	208	42	5	98	11	6	26	14
16/09/2025	Gynaecology	29	163	192	44	5	99	11	7	25	15
23/09/2025	Gynaecology	21	161	182	45	5	100	10	4	22	8
30/09/2025	Gynaecology	17	159	176	42	5	101	8	4	19	9
07/10/2025	Gynaecology	14	155	169	36	4	102	5	3	13	8
14/10/2025	Gynaecology	11	153	164	37	4	103	3	2	8	5
21/10/2025	Gynaecology	18	142	160	37	4	104	5	2	13	5
28/10/2025	Gynaecology	17	136	153	35	5	105	4	3	11	8
04/11/2025	Gynaecology	14	136	150	37	6	106	4	4	10	10
11/11/2025	Gynaecology	17	126	143	35	3	107	7	4	20	11
18/11/2025	Gynaecology	18	117	135	37	3	108	12	3	32	8
25/11/2025	Gynaecology	18	111	129	36	4	91	14	3	38	8
02/12/2025	Gynaecology	13	107	120	33	4	92	8	2	24	6
09/12/2025	Gynaecology	16	101	117	33	4	93	12	4	36	12
16/12/2025	Gynaecology	14	93	107	30	3	94	7	5	23	16
23/12/2025	Gynaecology	26	72	98	29	3	95	15	6	51	20
30/12/2025	Gynaecology	23	72	95	29	3	96	16	6	55	20
06/01/2026	Gynaecology	19	72	91	25	2	97	12	3	48	12
13/01/2026	Gynaecology	18	68	86	24	2	98	12	3	50	12
20/01/2026	Gynaecology	14	63	77	23	2	99	10	3	43	13
27/01/2026	Gynaecology	11	55	66	18	2	100	5	3	27	16
03/02/2026	Gynaecology	16	44	60	16	1	101	6	1	37	6

Graph 17: Gynaecology reduction of the target cohort

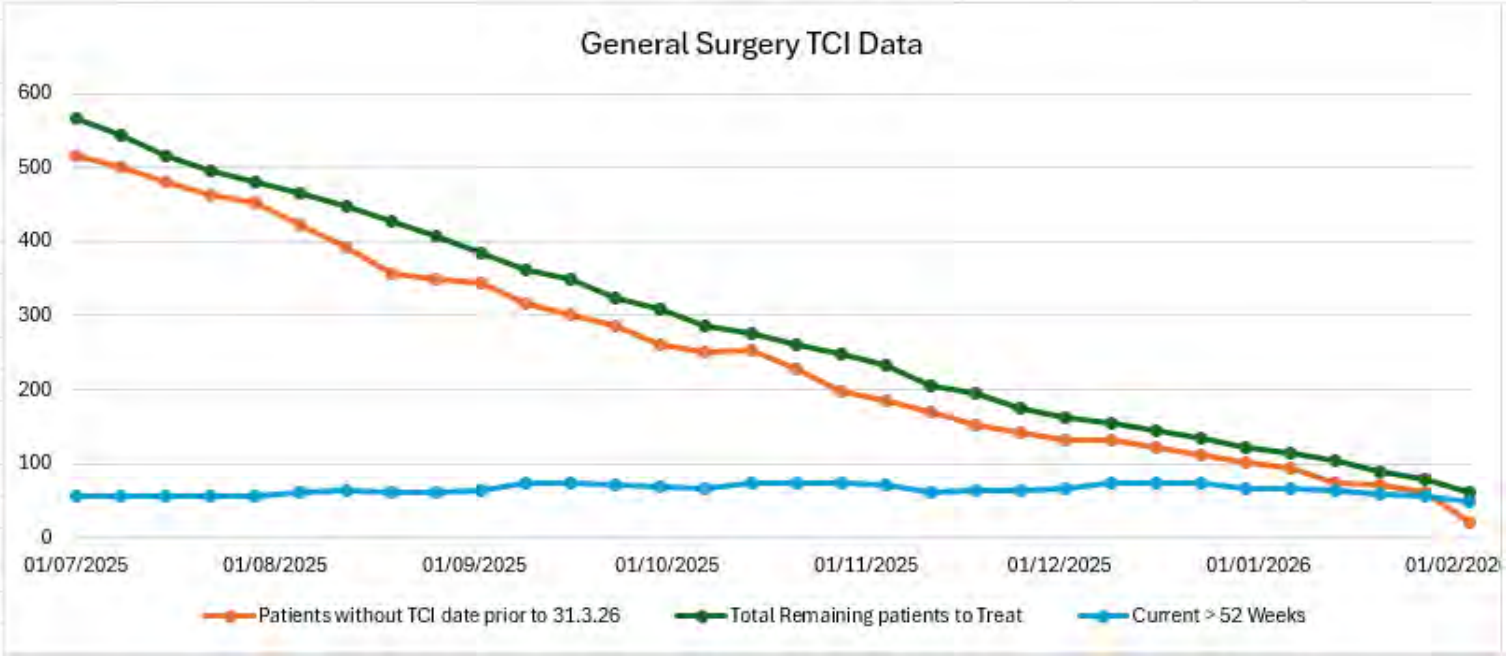


General Surgery

Table 7: General Surgery clearance of IPDC >52-week waiters

		Included: General Surgery Patients who would be waiting 52 weeks or over at 31st March 2026									
CensusPoint	SpecialtyName	Patients with TCI date prior to 31.3.26	Patients without TCI date prior to 31.3.26	Total Remaining patients to Treat	Current > 52 Weeks	Current > 78 Weeks	Longest Wait (weeks)	No > 52 Weeks Dated	No > 52 Weeks Unavailable	% of 52 Weeks Dated	% of 52 Weeks Unavailable
01/07/2025	General Surgery	51	515	566	57	5	95	4	15	7	26
08/07/2025	General Surgery	43	502	545	56	4	96	3	14	5	25
15/07/2025	General Surgery	37	480	517	56	6	97	4	14	7	25
22/07/2025	General Surgery	34	463	497	55	6	98	3	9	5	16
29/07/2025	General Surgery	28	453	481	57	5	99	4	9	7	15
05/08/2025	General Surgery	43	422	465	61	5	95	9	4	14	6
12/08/2025	General Surgery	57	391	448	64	5	96	10	8	15	12
19/08/2025	General Surgery	71	357	428	62	6	97	8	8	12	12
26/08/2025	General Surgery	58	350	408	62	10	98	9	8	14	12
02/09/2025	General Surgery	41	343	384	63	7	99	7	8	11	12
09/09/2025	General Surgery	47	316	363	74	8	100	10	9	13	12
16/09/2025	General Surgery	47	302	349	75	9	101	14	9	18	12
23/09/2025	General Surgery	40	285	325	72	8	102	12	9	16	12
30/09/2025	General Surgery	46	262	308	69	6	91	12	9	17	13
07/10/2025	General Surgery	34	251	285	66	5	92	4	10	6	15
14/10/2025	General Surgery	24	253	277	74	6	93	5	12	6	16
21/10/2025	General Surgery	35	227	262	74	5	94	11	9	14	12
28/10/2025	General Surgery	49	198	247	73	6	95	27	7	36	9
04/11/2025	General Surgery	49	185	234	72	5	96	22	11	30	15
11/11/2025	General Surgery	35	170	205	62	3	97	14	8	22	12
18/11/2025	General Surgery	42	153	195	63	2	98	20	10	31	15
25/11/2025	General Surgery	33	143	176	63	1	99	17	9	26	14
02/12/2025	General Surgery	30	132	162	67	1	100	14	12	20	17
09/12/2025	General Surgery	24	131	155	75	1	101	14	17	18	22
16/12/2025	General Surgery	24	121	145	74	2	102	15	17	20	22
23/12/2025	General Surgery	23	112	135	73	2	103	15	17	20	23
30/12/2025	General Surgery	20	102	122	67	4	104	7	16	10	23
06/01/2026	General Surgery	22	93	115	65	4	105	7	14	10	21
13/01/2026	General Surgery	32	73	105	63	5	106	14	17	22	26
20/01/2026	General Surgery	19	71	90	59	3	83	7	18	11	30
27/01/2026	General Surgery	17	62	79	55	3	84	9	19	16	34
03/02/2026	General Surgery	42	20	62	48	3	83	31	16	64	33

Graph 18: General Surgery reduction of the target cohort



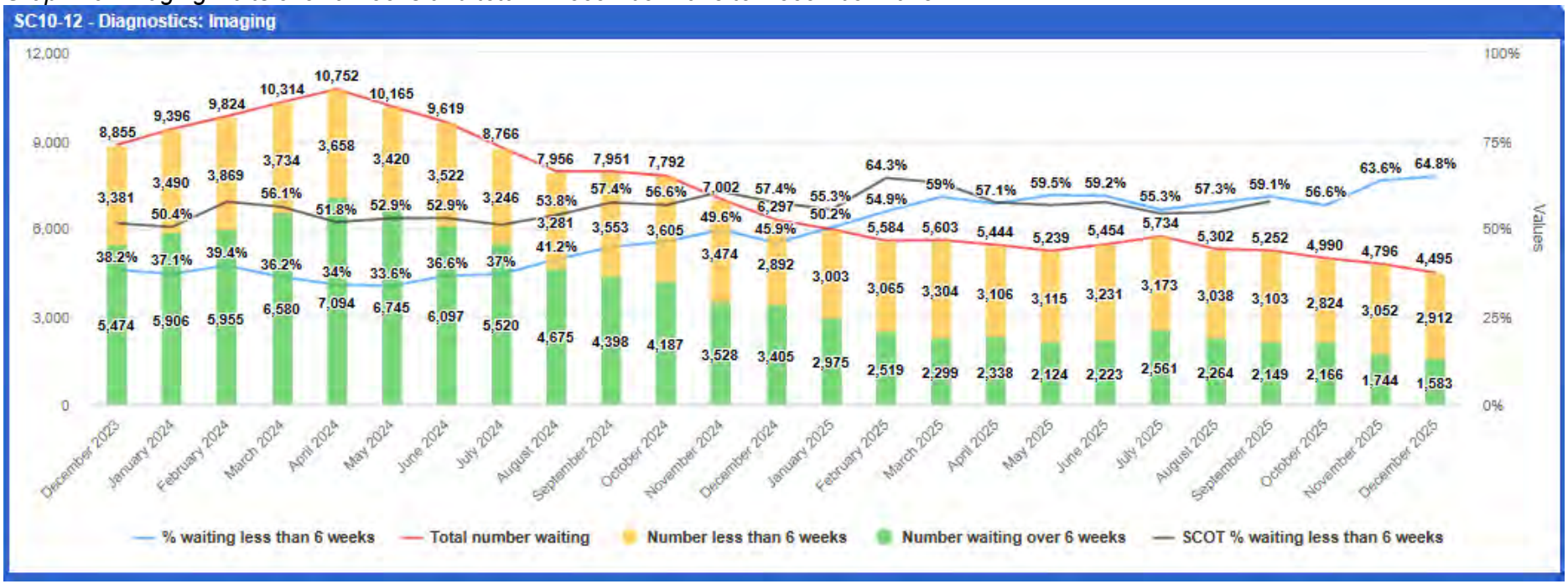
Diagnostics

The Diagnostic Waiting Times Standard states patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations.

Imaging

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total number waiting - Imaging	31-Dec-25	Reduction	4,495	4,796	5,978	▲	-	-
Monthly	Number waiting beyond 42 days - Imaging	31-Dec-25	0%	1,583	1,744	2,975	▲	-	-
Monthly	Percentage waiting less than 42 days - Imaging	31-Dec-25	100%	64.8%	63.6%	50.2%	▲	57.7%	30-Sep-25

Graph 19: Imaging waits over 6 weeks and total – December 2023 to December 2025



At the end of December 2025, 1,583 patients were waiting beyond the 6-week standard for imaging, a reduction from 2,975 in December 2024. Compliance with the 6 weeks standard was 64.8%.

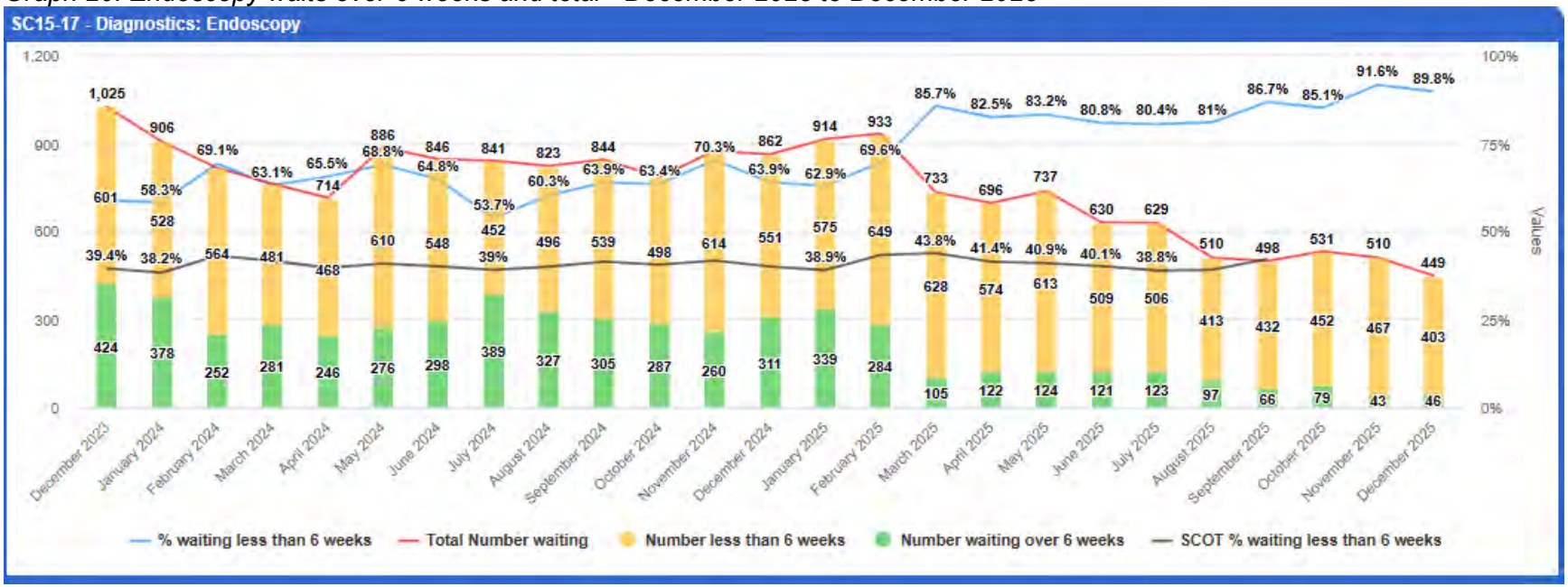
Patients continue to be seen on a priority basis with waiting lists actively monitored and managed on an ongoing basis. The total number of patients waiting for imaging in December 2025 was 4,495; compared with 5,978 in December 2024.

Endoscopy

Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Total number waiting - Endoscopy	31-Dec-25	Reduction	449	510	914	▲	-	-
Monthly	Number waiting beyond 42 days - Endoscopy	31-Dec-25	0	46	43	339	▲	-	-
Monthly	Percentage waiting less than 42 days - Endoscopy	31-Dec-25	100%	89.8%	91.6%	62.9%	▲	42.1%	30-Sep-25

Graph 20: Endoscopy waits over 6 weeks and total - December 2023 to December 2025



The current waiting list size for endoscopy (December 2025) is 449, compared to 914 in December 2024. NHS Forth Valley Endoscopy team is moving towards achieving the 6-week diagnostic standard. The size of the waiting list continues to reduce and the number of patients waiting over 6 weeks is also reducing. Performance has continued to be over 80% of patients accessing endoscopy within 6 weeks.

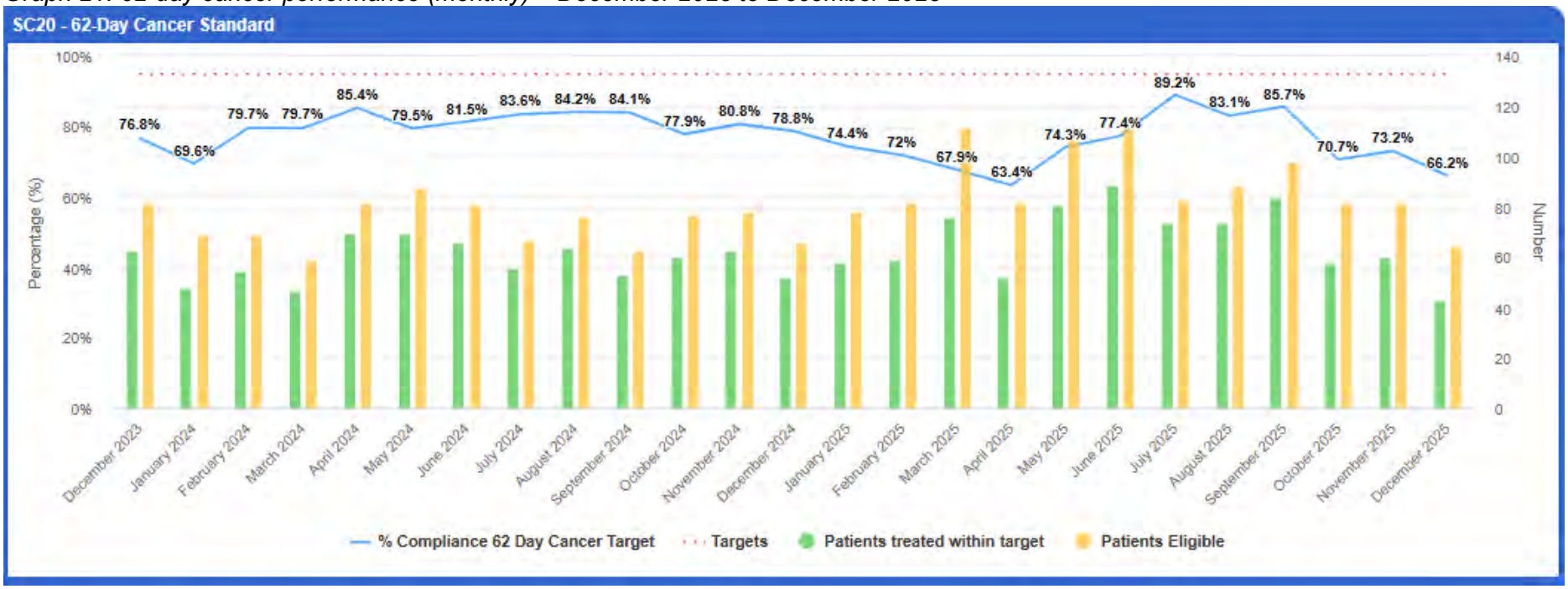
Based on the last published figures the NHS Scotland average performance for Endoscopy is 42.1% of patients were waiting less than the 6 week standard.

62-day Cancer Standard

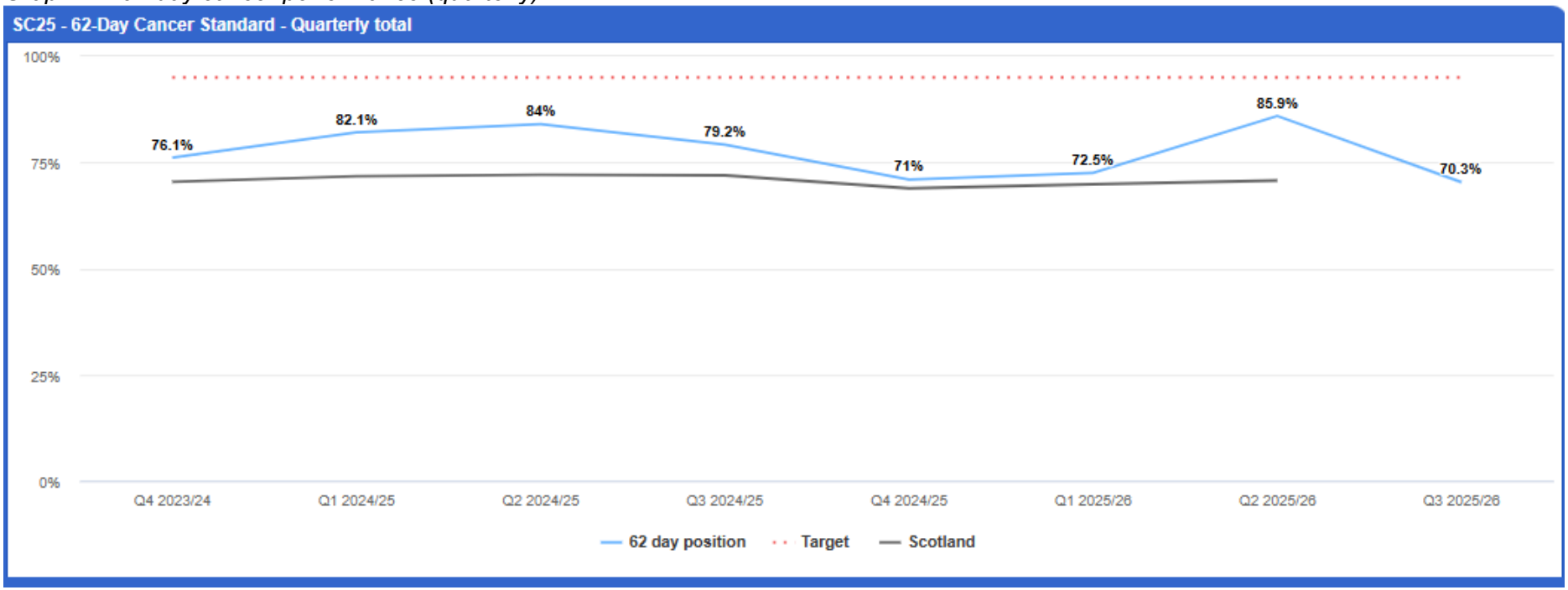
The 62-day standard states that 95% of eligible patients should wait no longer than 62 days from urgent suspicion of cancer referral to first cancer treatment.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	62 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	66.2%	73.2%	78.8%	▼	70.7%	30-Sep-25
Monthly	62 Day Cancer - Number seen within target against total	31-Dec-25	-	43/65	60/82	52/66	-	-	-
Quarterly	62 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	70.3%	85.9%	79.2%	▼	70.7%	30-Sep-25

Graph 21: 62-day cancer performance (monthly) – December 2023 to December 2025



Graph 22: 62-day cancer performance (quarterly)



Cancer services remain a priority for scheduled care. All Urgent Suspicion of Cancer referrals are tracked to support achievement of the 31-day and 62-day access targets. In areas where this is not reached priority measures are taken to address this. A robust monitoring system has been established to identify reasons for breaches and ensure a plan is in place to prevent further non-compliance where possible. Currently challenges remain in achieving the 95% target in urology with plans in place to address this on ongoing basis along with our tertiary service providers.

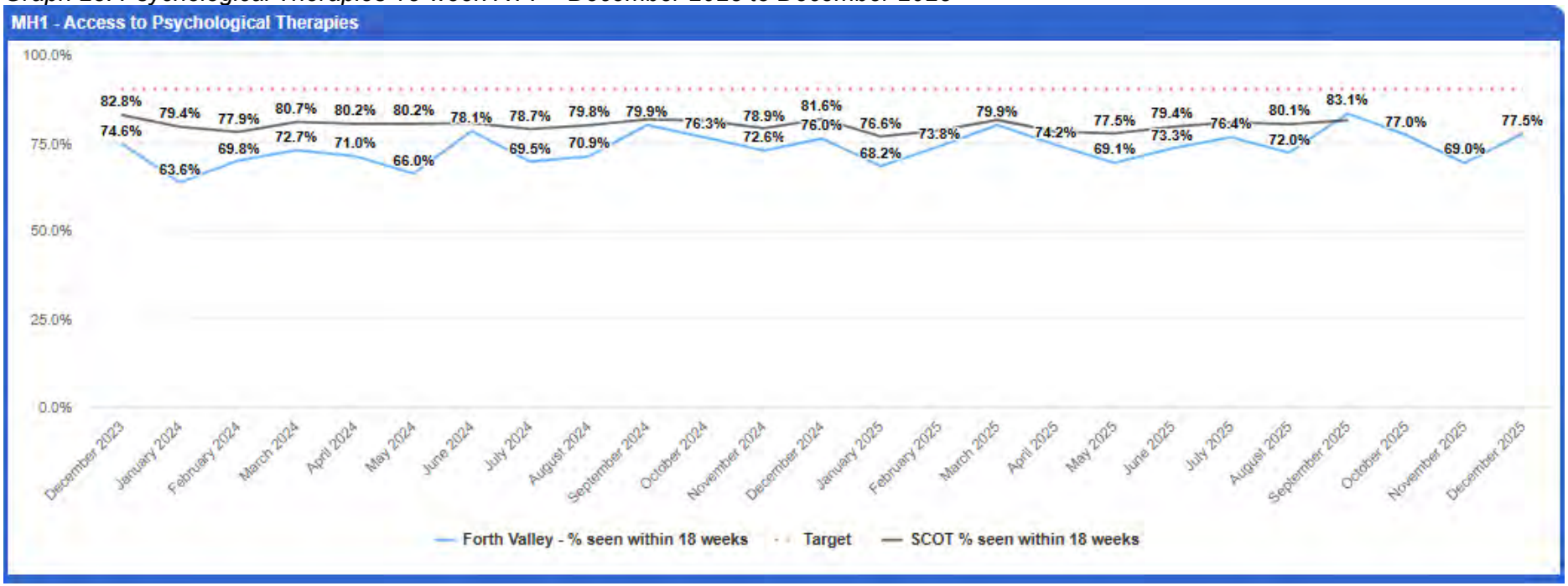
The number of patients being tracked on the 62-day cancer pathway is currently approximately 947 of which 15% are confirmed cancer patients.

Psychological Therapies

The national target is that 90% of patients should wait no longer than 18 weeks from referral to treatment for psychological therapies.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Psychological Therapies - 18 week RTT compliance	31-Dec-25	90%	77.5%	69.0%	76.0%	▲	81.2%	30-Sep-25
Monthly	Total Number Waiting for Pyschological Therapies Initial Assessment	31-Dec-25	Reduction	1,069	1,011	911	▼	-	-
Quarterly	Psychological Therapies - 18 week RTT compliance	31-Dec-25	90%	74.1%	77.1%	74.8%	▼	80.7%	30-Sep-25

Graph 23: Psychological Therapies 18-week RTT – December 2023 to December 2025



In December 2025, compliance with the RTT target was 77.5% continuing a relatively consistent pattern of around 70% compliance or above since June 2024. Monthly fluctuations are related to seasonal variation with peak holiday periods and winter illnesses adversely impact the numbers of people starting therapy with a clinician; the timing of therapeutic groups which enable a large number of people to start therapy simultaneously; and staff turnover.

In April 2025 waiting list projections were requested by Scottish Government and conducted by Public Health Scotland on NHS Forth Valley's behalf. These indicated that it would be extremely challenging to meet the RTT target without significant investment in additional resource.

May 2025 through to November 2025 has seen a reduction in numbers waiting for assessment which reflects service improvement work focusing on ensuring that all referrals accepted to the service met clear referral criteria, with referrals which did not meet criteria being redirected to more appropriate services. Improvement work within the service, including managing referral demand and rolling out Waiting Well calls is projected to positively impact the numbers of people waiting for an assessment by the end of this quarter. The total waiting list size for treatment had been slowly reducing since the introduction of an Improvement Plan in May 2025.

Patients that have been waiting an extended period are those with the most complex needs which require specific therapies that are delivered over a longer than average period and can only be delivered by the most highly trained professionals within the multi-professional service. Approval has been given to fund some additional capacity to deliver clinical sessions from January to March 2026. These sessions will be solely for those who have been waiting longest. This, in combination with a new clinical psychologist commencing in January after a period of vacancy, will support a reduction in the number of long waiting patients by the end of March.

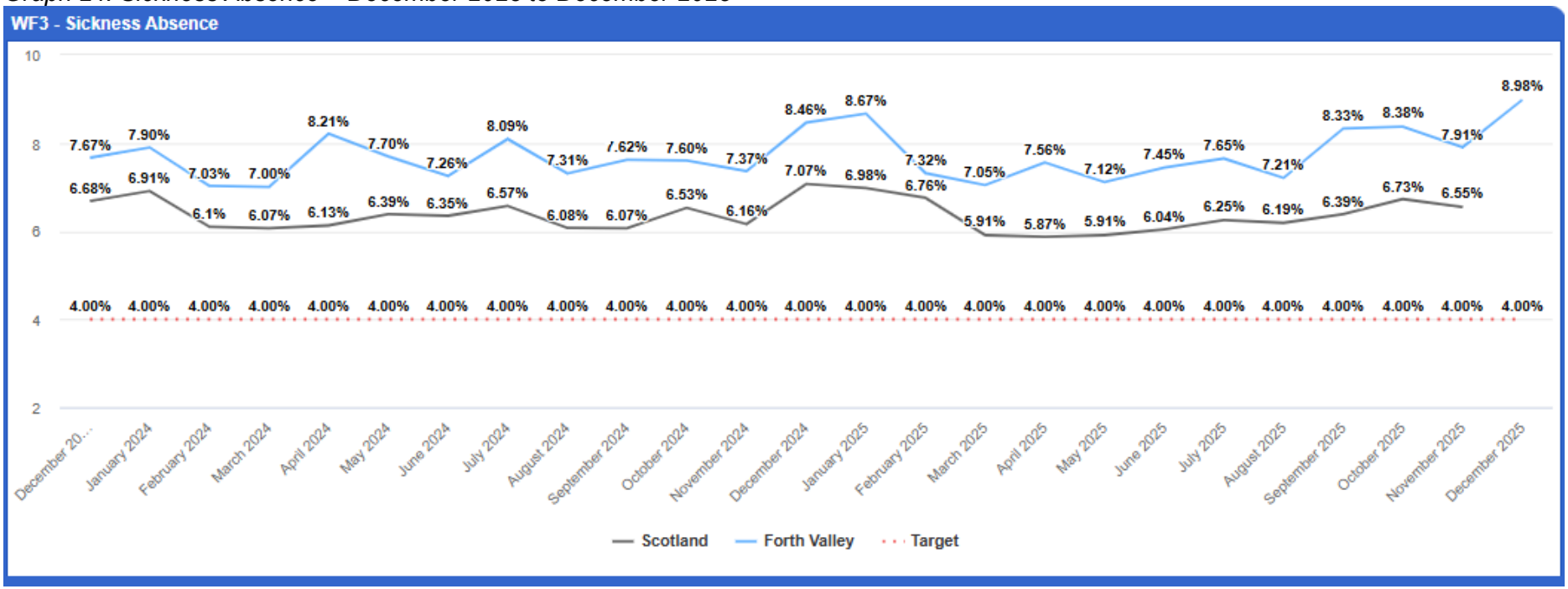
Section 3: Performance Report - Other Areas of Performance

Workforce

To reduce sickness absence to 4%

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Overall Absence	31-Dec-25	4.0%	8.98%	7.91%	8.46%	▼	6.55%	30-Nov-25
Rolling 12 mth	Overall Absence	30-Nov-25	-	7.80%	7.76%	7.67%	▼	6.36%	30-Nov-25

Graph 24: Sickness Absence – December 2023 to December 2025



The sickness absence target is 4.0%. Absence remains above the target at 8.98% in December 2025 noting deterioration from 8.46% in December 2024. The 12-month rolling average December 2024 to November 2025 is noted as, NHS Forth Valley 7.8%; Scotland 6.36%. Anxiety/stress/depression/other psychiatric illnesses are consistently the most reported reason for sickness absence with Cold/Cough/Flu the second highest reason.

The management of absence and the improvement of staff wellbeing remain key priorities for NHS Forth Valley noting a 2% reduction in absence has been included in the Executive Leadership Team objectives. This issue is being addressed through Directorate reviews and through the Whole System Leadership Team.

Work to improve attendance is focussed on the 3 key areas of Attendance Management, Occupational Health and Staff Wellbeing. The launch of the new Workforce Wellbeing Framework 2025-2029 is intended to ensure a comprehensive and coordinated approach to enabling and supporting the wellbeing and mental health of our workforce. In addition, an Attendance Management Plan has been developed in partnership with staff side colleagues with regular progress updates to the Staff Governance Committee

A range of Occupational Health clinical services are providing staff with pathways to counselling, psychology, physiotherapy, management and self-referrals to align with Once for Scotland Policies. Awareness sessions, aimed at improving managers ability to make more accurate referrals to OH clinical pathways are delivered regularly to educate managers through a Management Referral training package. A proactive Occupational Health consultation advice line is established and increases a person-centred approach to enable individuals with access the right care at the right time.

Issues in relation to sickness absence and workforce continue to be examined and discussed at the bi-monthly Staff Governance Committee.

Unavailability

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Outpatient Unavailability	31-Jan-26	Monitor	0.4%	0.7%	0.6%	▲	1.0%	31-Dec-25
Monthly	Inpatient/Day case Unavailability	31-Jan-26	Monitor	3.7%	4.1%	2.2%	▼	3.9%	31-Dec-25

Monitoring of patient unavailability is an Audit Scotland recommendation and refers to the percentage of outpatient or inpatient/daycase unavailability as a proportion of the total waiting list size.

- Outpatient unavailability in January 2026 was 0.4% of the total waiting list.
- Inpatient/daycase unavailability in January 2026 was 3.7% a reduction from 4.1% in January 2025. The unavailability rate is less than 6% for all specialties except Surgical Paediatrics (8%) and General Surgery (7.34%). The highest in terms of numbers are Orthopaedics with 130 patients unavailable (4.99%) and General Surgery with 63 patients unavailable (7.34%).

Did Not Attend (DNA)

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	New Acute Services Outpatient % DNA	31-Jan-26	5%	4.5%	4.8%	5.0%	▲	6.5%	31-Dec-25
Monthly	Return Acute Services Outpatient % DNA	31-Jan-26	5%	4.5%	4.7%	5.6%	▲	-	-

The new outpatient DNA rate across acute services in January 2026 is noted as 4.5% which is an improvement from the position in January 2025 of 5.0%. Variation across specialties continues with rates ranging from 23.8% to 0%. The biggest impact in terms of the number of DNAs can be seen in Ophthalmology 7.36% (54 patients).

The return outpatient DNA rate across acute services in January 2025 was 4.5%. There continues to be a high number of DNAs in Ophthalmology with 234 patients (3.83%), Orthopaedics 100 patients (4.2%), Dermatology 87 patients (4.08%) and Orthodontics 83 patients (6.14%).

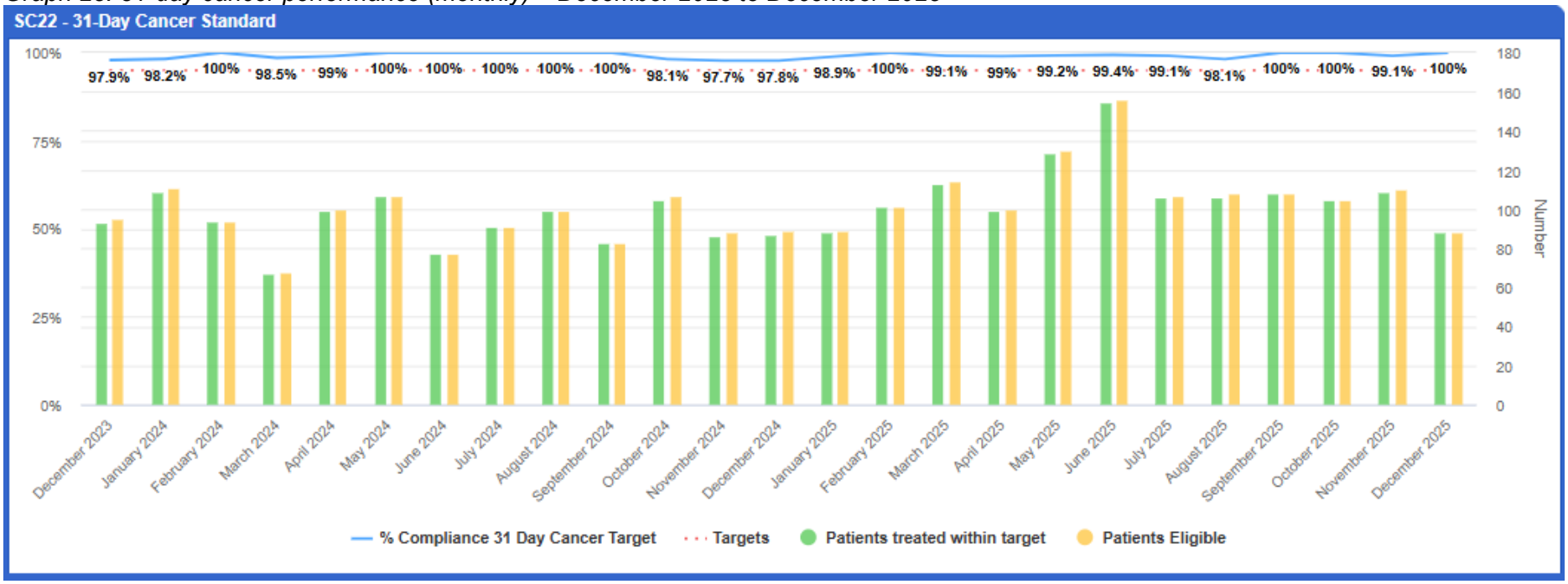
A number of actions are ongoing to support a reduction in the number of DNAs including the roll out of patient focus booking. Application of the Access Policy is actively supported and there is ongoing benchmarking against national DNAs and removal rates. Patient information provides detail on the process to cancel or change an appointment with the relevant contact information.

31- Day Cancer Standard

The 31-day standard states that 95% of all patients should wait no more than 31 days from decision to treat to first cancer treatment.

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	31 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	100.0%	99.1%	97.8%	▲	95.6%	30-Sep-25
Monthly	31 Day Cancer Target - Number seen within target against total	31-Dec-25	-	88/88	109/110	87/89	-	-	-
Quarterly	31 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	99.7%	99.1%	98.0%	▲	95.1%	30-Sep-25

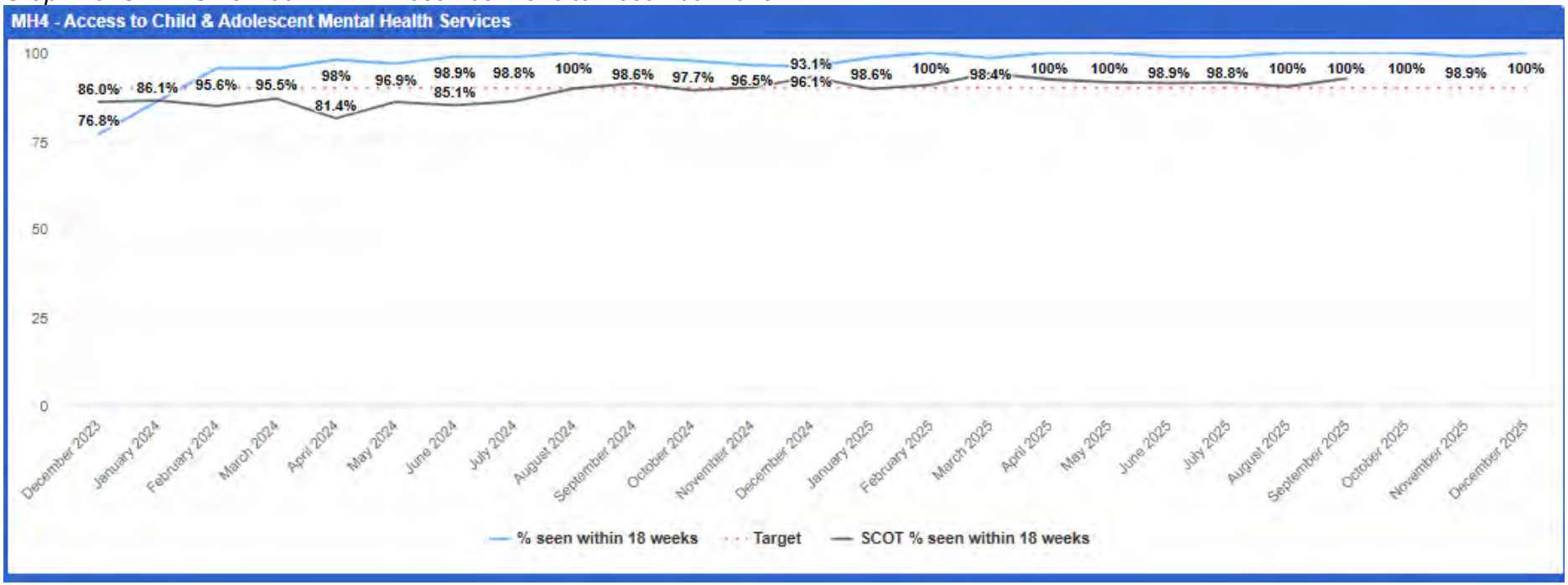
Graph 25: 31-day cancer performance (monthly) – December 2023 to December 2025



Child & Adolescent Mental Health Services (CAMHS)

FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE
Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Dec-25	90%	100.0%	98.9%	96.1%	▲	92.7%	30-Sep-25
Monthly	Total Number Waiting for CAMHS Initial Assessment	31-Dec-25	Reduction	245	136	54	▼	-	-
Quarterly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Dec-25	90%	99.5%	99.4%	96.8%	▲	91.6%	30-Sep-25

Graph 26: CAMHS 18-week RTT – December 2023 to December 2025



December 2025 numbers show we are continuing to perform above target with 100% of patients started treatment within 18 weeks of referral.

Section 4: Performance Scorecard

BETTER CARE													
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS REPORTING PERIOD	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	NOTES
HOSPITAL STANDARDISED MORTALITY RATE													
MR1	SG	Rolling 12 mth	Hospital Standardised Mortality Ratio (HSMR)	30-Sep-25	</= 1.00	0.94	0.92	0.98	▲	1.00	30-Sep-25	-	Hospital Standardised Mortality Ratio (HSMR) is a measure of mortality adjusted to take account of some of the factors known to affect the underlying risk of death. The data is calculated on a rolling 12 months and published quarterly.
UNSCHEDULED CARE													
	FV	Monthly	Total Number of ED Attendances	31-Jan-26	Reduction	5,424	5,238	4,966	▼	-	-	-	
US1	SG	Monthly	Number of ED Attendances (4 hour access target)	31-Jan-26	Reduction	5,424	5,238	4,731	▼	-	-	-	Number of ED attandances and a target of 'Reduction' is relevant in relation to capacity and flow. National standard for A&E waiting times is that unplanned and new planned attendances at an A&E service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care such as EDs, assessment units, minor injury units, community hospitals, anywhere where emergency care type activity takes place. The measure is the proportion of all attendances that are admitted, transferred or discharged within four hours of arrival. 95% of patients should wait no longer than four hours from arrival to admission, discharge or transfer for A&E treatment.
US2	SG	Monthly	Emergency Department % compliance against 4 hour access target	31-Jan-26	95%	45.0%	49.2%	46.4%	▼	63.5%	31-Dec-25	✓	
US3	S5	Monthly	Number that waited >4 hours in ED	31-Jan-26	Reduction	2,985	2,663	2,537	▼	-	-	-	
US4	SG	Monthly	Number that waited >8 hours in ED	31-Jan-26	Reduction	1,526	1,218	1,286	▼	-	-	-	
US5	SG	Monthly	Number that waited >12 hours in ED	31-Jan-26	Reduction	784	559	720	▼	-	-	-	
US6	SG	Monthly	Number that waited >23 hours in ED	31-Jan-26	Reduction	150	76	145	▼	-	-		
	FV	Monthly	Total Number of MIU Attendances	31-Jan-26	Reduction	1,506	1,318	1,475	▼	-	-	-	
US7	SG	Monthly	Number of MIU Attendances (4 hour access target)	31-Jan-26	Reduction	1,506	1,318	736	▼	-	-	-	
US8	SG	Monthly	Minor Injuries Unit % compliance against 4 hour target	31-Jan-26	95%	99.9%	99.9%	99.7%	▼	-	-	-	
US9	SG	Monthly	NHS Forth Valley Overall % compliance against 4 hour target	31-Jan-26	95%	56.9%	59.4%	53.6%	▲	67.0%	31-Dec-25	✓	
US12	FV	Monthly	Number of Rapid Assessment and Care Unit New Attendances	31-Jan-26	-	521	467	535	-	-	-	-	
US13	FV	Monthly	Number of Rapid Assessment and Care Unit Scheduled Return Attendances	31-Jan-26	-	171	181	132	-	-	-	-	
US14	FV	Monthly	Number of Re-directions from ED	31-Jan-26	-	615	515	493	-	-	-	-	Redirections from ED to a more suitable setting enabling receipt of the right care, in the right place at the right time
US15	FV	Monthly	Re-directions from ED %	31-Jan-26	-	11.3%	9.8%	9.9%	-	-	-	-	
US16	FV	Monthly	Number of Emergency Admissions	31-Jan-26	Reduction	3,498	3,423	3,163	▼	-	-	-	Admission to a hospital bed following an attendance at an A&E service.
OUT OF HOURS													
OH1	FV	Monthly	Number of Out of Hours Presentations	31-Jan-26	Reduction	5,887	5,428	5,000	▼	-	-	-	
	FV	Monthly	Advice	31-Jan-26	-	3,995	3,728	3,424	-	-	-	-	
	FV	Monthly	Attend OOH Appointment	31-Jan-26	-	1,567	1,400	1,255	-	-	-	-	
	FV	Monthly	Home Visit	31-Jan-26	-	297	257	208	-	-	-	-	
	FV	Monthly	Mental Health	31-Jan-26	-	27	40	39	-	-	-	-	
	FV	Monthly	SAS In Attendance	31-Jan-26	-	0	0	70	-	-	-	-	
	FV	Monthly	Remote Consultation	31-Jan-26	-	1	3	4	-	-	-	-	
OH2	FV	Monthly	Out of Hours % Rota Fill	31-Jan-26	-	99%	97%	98%	▲	-	-	-	

SCHEDULED CARE													
OUTPATIENTS													
SC1	SG	Monthly	Total Number of New Outpatients Waiting	31-Jan-26	Reduction	17,599	17,544	12,661	▼	-	-	✓	An outpatient is categorised as a new outpatient at his first meeting with a consultant or his representative following an outpatient referral. Outpatients whose first clinical interaction follows an inpatient episode are excluded. Scotland position now monthly for SOT.
			Forth Valley	31-Jan-26	Reduction	17,074	16,891			-	-	-	
			Mutual Aid	31-Jan-26	Reduction	525	653			-	-	-	
SC2	SG	Monthly	Number of New Outpatients waiting over 12 weeks	31-Jan-26	Reduction	7,023	6,487	3,738	▼	-	-	✓	
			Forth Valley	31-Jan-26	Reduction	6,730	6,000			-	-	-	
			Mutual Aid	31-Jan-26	Reduction	293	487			-	-	-	
		Monthly	Number of New Outpatients waiting over 52 weeks	31-Jan-26	0	209	276	160	▼	-	-	✓	
			Forth Valley	31-Jan-26	0	67	69						
			Mutual Aid	31-Jan-26	0	142	207						
SC3	SG	Monthly	New Outpatients waiting under 12 weeks %	31-Jan-26	95%	60.1%	63.0%	70.5%	▼	43.2%	31-Dec-25	✓	
			Forth Valley	31-Jan-26	95%	60.6%	64.5%			-	-	-	
			Mutual Aid	31-Jan-26	95%	44.2%	25.4%			-	-	-	
SC6	Audit	Monthly	Outpatient Unavailability	31-Jan-26	Monitor	0.4%	0.7%	0.6%	▲	1.0%	31-Dec-25	✓	Unavailability, for patients without a date for treatment, is a period of time when the patient is unavailable for treatment. Unavailability can be for medical or social reasons. Scotland position quarterly
SC7	FV	Monthly	New Acute Services Outpatient % DNA	31-Jan-26	5%	4.5%	4.8%	5.0%	▲	6.5%	31-Dec-25	-	A patient may be categorised as did not attend (DNA) when the hospital is not notified in advance of the patient's unavailability to attend on the offered admission date, or for any appointment. Scotland position quarterly
SC8	FV	Monthly	Return Acute Services Outpatient % DNA	31-Jan-26	5%	4.5%	4.7%	5.6%	▲	-	-	-	
DIAGNOSTICS - Imaging													
SC10	SG	Monthly	Total number waiting - Imaging	31-Dec-25	Reduction	4,495	4,796	5,978	▲	-	-		Waiting times standard is that patients should be waiting no more than six weeks for one of the eight key diagnostic tests and investigations - Xray, Ultrasound, CT, MRI, Colonoscopy, Upper Endoscopy, Lower Endoscopy, Cystoscopy Scotland position monthly, available quarterly
SC11	SG	Monthly	Number waiting beyond 42 days - Imaging	31-Dec-25	0	1,583	1,744	2,975	▲	-	-	-	
SC12	SG	Monthly	Percentage waiting less than 42 days - Imaging	31-Dec-25	100%	64.8%	63.6%	50.2%	▲	57.7%	30-Sep-25	✓	
DIAGNOSTICS - Endoscopy													
SC15	SG	Monthly	Total number waiting - Endoscopy	31-Dec-25	Reduction	449	510	914	▲	-	-		
SC16	SG	Monthly	Number waiting beyond 42 days - Endoscopy	31-Dec-25	0	46	43	339	▲	-	-	-	
SC17	SG	Monthly	Percentage waiting less than 42 days - Endoscopy	31-Dec-25	100%	89.8%	91.6%	62.9%	▲	42.1%	30-Sep-25	✓	
CANCER													
SC20	SG	Monthly	62 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	66.2%	73.2%	78.8%	▼	70.7%	30-Sep-25	✓	Cancer services remain a priority for scheduled care. All Urgent Suspicion of Cancer referrals are tracked to support achievement of the 62 and 31 day access targets. In areas where this is not reached priority measures are taken to address this. A robust monitoring system has been established to identify reasons for breaches and ensure a plan is in place to prevent further non-compliance. The 62-day standard states that 95% of eligible patients should wait no longer than 62 days from urgent suspicion of cancer referral to first cancer treatment. The 31-day standard states that 95% of all patients should wait no more than 31 days from decision to treat to first cancer treatment.
SC21	SG	Monthly	62 Day Cancer - Number seen within target against total	31-Dec-25	-	43/65	60/82	52/66	-	-	-	-	
	SG	Monthly	62 Day Cancer - Breast - Percentage compliance against target	31-Dec-25	95%	100.0%	94.7%	100.0%	▲	92.7%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Breast - Number seen within target against total	31-Dec-25	-	9/9	20/20	13/13	-	-	-	-	
	SG	Monthly	62 Day Cancer - Colorectal - Percentage compliance against target	31-Dec-25	95%	66.7%	66.7%	75.0%	▼	75.5%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Colorectal - Number seen within target against total	31-Dec-25	-	4/6	6/9	3/4	-	-	-	-	
	SG	Monthly	62 Day Cancer - Cervical - Percentage compliance against target	31-Dec-25	95%	100.0%	n/a	100.0%	▲	50.0%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Cervical - Number seen within target against total	31-Dec-25	-	1/1	0/0	1/1	-	-	-	-	
	SG	Monthly	62 Day Cancer - Head & Neck - Percentage compliance against target	31-Dec-25	95%	75.0%	66.7%	50.0%	▲	66.2%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Head & Neck - Number seen within target against total	31-Dec-25	-	3/4	2/3	1/2	-	-	-	-	
	SG	Monthly	62 Day Cancer - Lung - Percentage compliance against target	31-Dec-25	95%	72.7%	85.7%	76.9%	▼	81.2%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Lung - Number seen within target against total	31-Dec-25	-	8/11	12/14	10/13	-	-	-	-	
	SG	Monthly	62 Day Cancer - Lymphoma - Percentage compliance against target	31-Dec-25	95%	100.0%	100.0%	66.7%	▲	82.9%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Lymphoma - Number seen within target against total	31-Dec-25	-	1/1	1/1	2/3	-	-	-	-	
	SG	Monthly	62 Day Cancer - Melanoma - Percentage compliance against target	31-Dec-25	95%	100.0%	100.0%	100.0%	▲	80.7%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Melanoma - Number seen within target against total	31-Dec-25	-	5/5	3/3	3/3	-	-	-	-	
	SG	Monthly	62 Day Cancer - Ovarian - Percentage compliance against target	31-Dec-25	95%	n/a	100.0%	100.0%	▲	84.0%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Ovarian - Number seen within target against total	31-Dec-25	-	0/0	1/1	2/2	-	-	-	-	
	SG	Monthly	62 Day Cancer - Upper GI - Percentage compliance against target	31-Dec-25	95%	88.9%	91.7%	83.3%	▲	84.2%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Upper GI - Number seen within target against total	31-Dec-25	-	8/9	11/12	5/6	-	-	-	-	
	SG	Monthly	62 Day Cancer - Urology - Percentage compliance against target	31-Dec-25	95%	21.1%	21.1%	63.2%	▼	42.8%	30-Sep-25	-	
	SG	Monthly	62 Day Cancer - Urology - Number seen within target against total	31-Dec-25	-	4/19	4/19	12/19	-	-	-	-	
SC22	SG	Monthly	31 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	100.0%	99.1%	97.8%	▲	95.6%	30-Sep-25	✓	
SC23	SG	Monthly	31 Day Cancer Target - Number seen within target against total	31-Dec-25	-	88/88	109/110	87/89	-	-	-	-	
SC24	SG	Quarterly	62 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	70.3%	85.9%	79.2%	▼	70.7%	30-Sep-25	✓	
SC25	SG	Quarterly	31 Day Cancer Target - Percentage compliance against target	31-Dec-25	95%	99.7%	99.1%	98.0%	▲	95.1%	30-Sep-25	✓	

INPATIENTS & DAYCASES													
SC26	SG	Quarterly	Number of patients that waited >12 weeks - Completed Wait	31-Dec-25	0	1,847	2,054	1,386	-	-	-	-	
SC27	SG	Quarterly	% Compliance with 12 week TTG Standard	31-Dec-25	100%	35.4%	33.6%	44.6%	▼	57.9%	31-Dec-25	-	
SC28	SG	Monthly	Total Number of Inpatients/Day cases Waiting	31-Jan-26	Reduction	7,730	7,672	6,616	▼	-	-	✓	
			Forth Valley	31-Jan-26	Reduction	7,457	7,329		-	-	-	-	
			Mutual Aid	31-Jan-26	Reduction	75	65		-	-	-	-	
			NTC	31-Jan-26	Reduction	198	278		-	-	-	-	
SC29	SG	Monthly	Number of Inpatients/Day cases waiting over 12 weeks	31-Jan-26	Reduction	4,982	4,895	4,189	▼	-	-	✓	
			Forth Valley	31-Jan-26	Reduction	4,804	4,642		-	-	-	-	Treatment Time Guarantee (TTG) - There is a 12 week maximum waiting time for the treatment of all eligible patients who are due to receive planned treatment delivered on an inpatient or day case basis. Scotland position quarterly
			Mutual Aid	31-Jan-26	Reduction	24	28		-	-	-	-	
			NTC	31-Jan-26	Reduction	154	225		-	-	-	-	
		Monthly	Number of Inpatients/Day cases waiting over 52 weeks	31-Jan-26	0	362	443	554	▲	-	-	✓	
			Forth Valley	31-Jan-26	0	332	400		-	-	-	-	
			Mutual Aid	31-Jan-26	0	1	1		-	-	-	-	
			NTC	31-Jan-26	0	29	42		-	-	-	-	
SC30	SG	Monthly	Percentage of Inpatients/Day cases waiting under 12 weeks	31-Jan-26	100%	35.5%	36.2%	36.7%	▼	36.4%	31-Dec-25	✓	
			Forth Valley	31-Jan-26	100%	35.6%	36.7%		-	-	-	-	
			Mutual Aid	31-Jan-26	100%	68.0%	56.9%		-	-	-	-	
			NTC	31-Jan-26	100%	22.2%	19.1%		-	-	-	-	
SC33	Audit	Monthly	Inpatient/Day case Unavailability	31-Jan-26	Monitor	3.7%	4.1%	2.2%	▼	3.9%	31-Dec-25	✓	Unavailability, for patients without a date for treatment, is a period of time when the patient is unavailable for treatment. Unavailability can be for medical or social reasons. Scotland position quarterly.
READMISSIONS													
R1	FV	Monthly	Readmissions - Surgical 7 day	31-Jan-26	Reduction	3.8%	2.3%	2.9%	▼	-	-	-	This is the measure of patients readmitted as an emergency to a medical/surgical specialty within 7 days or 28 days of the index admission. Emergency readmissions as a percentage of all admissions.
R2	FV	Monthly	Readmissions - Surgical 28 day	31-Jan-26	Reduction	7.0%	6.4%	6.2%	▼	-	-	-	
R3	FV	Monthly	Readmissions - Medical 7 day	31-Jan-26	Reduction	1.6%	1.4%	1.1%	▼	-	-	-	
R4	FV	Monthly	Readmissions - Medical 28 day	31-Jan-26	Reduction	5.0%	3.8%	4.0%	▼	-	-	-	
MENTAL HEALTH													
PSYCHOLOGICAL THERAPIES													
MH1	SG	Monthly	Psychological Therapies - 18 week RTT compliance	31-Dec-25	90%	77.5%	69.0%	76.0%	▲	81.2%	30-Sep-25	✓	
MH2	FV	Monthly	Total Number Waiting for Pyschological Therapies Initial Assessment	31-Dec-25	Reduction	1069	1011	911	▼	-	-	-	
MH3	SG	Quarterly	Psychological Therapies - 18 week RTT compliance	31-Dec-25	90%	74.1%	77.1%	74.8%	▼	80.7%	30-Sep-25	✓	
CHILD & ADOLESCENT MENTAL HEALTH SERVICES													The 18 Weeks RTT is a whole journey waiting time standard from initial referral to the start of treatment. The standard has been determined by the Scottish Government and states that 90.0% of patients should have a completed pathway within 18 weeks.
MH4	SG	Monthly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Dec-25	90%	100.0%	98.9%	96.1%	▲	92.7%	30-Sep-25	✓	
MH5	FV	Monthly	Total Number Waiting for CAMHS Initial Assessment	31-Dec-25	Reduction	245	136	54	▼	-	-	-	
MH6	SG	Quarterly	Child & Adolescent Mental Health Services - 18 week RTT compliance	31-Dec-25	90%	99.5%	99.4%	96.8%	▲	91.6%	30-Sep-25	✓	
SUBSTANCE USE													
SM1	SG	Quaterly	% Compliance with the 3 Week target - ADP (excluding Prisons)	30-Sep-25	90%	100.0%	100.0%	99.5%	▲	94.7%	30-Sep-25	✓	The Scottish Government set a Standard that 90% of people referred for help with problematic drug or alcohol use will wait no longer than three weeks for specialist treatment that supports their recovery.
SM2	SG	Quaterly	% Compliance with the 3 Week target - Prisons	30-Sep-25	90%	100.0%	98.5%	93.5%	▲	93.9%	30-Sep-25	✓	
COMPLAINTS													
C1		Monthly	% Compliance Forth Valley (inc. prisons)	31-Dec-25	100%	79.1%	75.5%	67.9%	▲	-	-	✓	Complaints monitoring and feedback is a standing item on the Clinical Governance Committee agenda
C2		Monthly	% Compliance Stage 1 (inc. prisons)	31-Dec-25	100%	92.0%	79.7%	77.8%	▲	-	-	✓	
C3		Monthly	% Compliance Stage 2 (inc. prisons)	31-Dec-25	100%	40.9%	40.5%	16.7%	▲	-	-	✓	

BETTER WORKFORCE													
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	
WF3	SG	Monthly	Overall Absence	31-Dec-25	4.0%	8.98%	7.91%	8.46%	▼	6.55%	30-Nov-25	✓	Hours lost due to sickness absence / total hours available (%). Short Term Absence - a period of sickness absence of 28 days or less Long Term Absence - a period of sickness absence lasting over 28 days Absence Management is a standing item on the Staff Governance Committee agenda.
WF4	FV	Monthly	Short Term Absence	31-Dec-25	-	3.35%	2.79%	3.48%	▲	-	-	-	
WF5	FV	Monthly	Long Term Absence	31-Dec-25	-	5.63%	5.11%	5.19%	▼	-	-	-	
WF6	FV	Rolling 12 mth	Overall Absence	30-Nov-25	-	7.80%	7.76%	7.67%	▼	6.36%	30-Nov-25	-	
BETTER VALUE													
REF	Target Type	FREQUENCY	MEASURE	DATE	TARGET	CURRENT POSITION	PREVIOUS POSITION	PREVIOUS YEAR	DIRECTION OF TRAVEL (YEAR ON YEAR)	SCOTLAND POSITION	SCOTLAND DATE	RUN CHART	
DELAYED DISCHARGES													
VA1	FV	Monthly	Delayed Discharges - excl. Code 9 & Guardianship (Standard Delays)	31-Jan-26	Reduction	54	46	84	▲	-	-	✓	A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date
			Falkirk	31-Jan-26	Reduction	32	27	50	▲	-	-	✓	
			Clackmannanshire	31-Jan-26	Reduction	7	8	9	▲	-	-	✓	
			Stirling	31-Jan-26	Reduction	15	9	20	▲	-	-	✓	
			Outwith Forth Valley	31-Jan-26	Reduction	2	2	5	▲	-	-	✓	
VA2	FV		Code 9 & Guardianship Delays	31-Jan-26	Reduction	57	56	44	▼	-	-	✓	
			Falkirk	31-Jan-26	Reduction	25	27	19	▼	-	-	✓	
			Clackmannanshire	31-Jan-26	Reduction	13	10	12	▼	-	-	✓	
			Stirling	31-Jan-26	Reduction	19	17	8	▼	-	-	✓	
			Outwith Forth Valley	31-Jan-26	Reduction	2	2	5	▲	-	-	✓	
VA3	FV		Total Bed Days Occupied by Delayed Discharges (Standard Delays)	31-Jan-26	Reduction	1,644	1,744	2,097	▲	-	-	✓	
			Falkirk	31-Jan-26	Reduction	1,073	955	1,385	▲	-	-	✓	
			Clackmannanshire	31-Jan-26	Reduction	181	194	128	▼	-	-	✓	
			Stirling	31-Jan-26	Reduction	352	493	43	▼	-	-	✓	
			Outwith Forth Valley	31-Jan-26	Reduction	38	102	241	▲	-	-	✓	
VA4	FV	Daily	Number waiting for a Community Bed	31-Jan-26	Reduction	46	33	43	▼	-	-	-	
AVERAGE LENGTH OF STAY													
VA4	FV	Monthly	FVRH Acute Wards Average Length of Stay (Days)	31-Jan-26	Reduction	5.96	6.12	7.33	▲	-	-	-	This is the mean length of stay (in days) experienced by inpatients in FVRH Acute wards, does not include MH or W&C.
EFFICIENCY													
E1	FV	Monthly	ED Attendances per 100,000 of the population - Forth Valley	31-Jan-26	Reduction	1,730	1,791	1,593	▼	-	-	-	
E2	FV	Rolling 12 mth	Acute Emergency Bed days per 1,000 population - Forth Valley	31-Jan-26	Reduction	767	813	791	▲	-	-	-	
E3	FV	Monthly	% Bed Occupancy - FVRH	31-Jan-26	Reduction	105.3%	97.3%	118.0%	▲	-	-	-	The percentage occupancy is the percentage of average available staffed beds that were occupied by inpatients during the period. 85% is the nationally agreed standard supporting optimum flow
E4	FV	Monthly	% Bed Occupancy - Assessment Units	31-Jan-26	Reduction	85.8%	77.7%	111.7%	▲	-	-	-	
E5	FV	Monthly	% Bed Occupancy - ICU	31-Jan-26	Reduction	90.2%	76.1%	93.0%	▲	-	-	-	

EQUITABLE													
EQ1		Rolling 3 year	Scottish Breast Screening Programme	2020/23	70%	76.4%	74.4%	76.4%	◄►	75.9%	2020/23	-	Percentage uptake (three-year rolling periods), females aged 50-70 years
EQ2		Annually	Scottish Cervical Screening Programme	2023/2024	-	66.9%	66.3%	72.5%	▼	63.3%	2023/24	-	The percentage of eligible women who are up-to-date with their screening participation
EQ3		Rolling 2 year	Scottish Bowel Screening Programme	2022/24	60%	66.2%	66.6%	66.6%	▼	65.7%	2022/24	-	Overall uptake of screening - percentage of people with a final outright screening test result, out of those invited (2 year reporting period)
EQ4		Annually	Scottish Abdominal Aortic Aneurysm (AAA) screening programme	2023/24	75%	73.4%	24.1%	24.1%	▲	77.3%	2023/24	-	Percentage of eligible population who are tested before age 66 and 3 months
		Annually	Surveillance AAA scan (quarterly)	2023/24	90%	100.0%	84.4%	81.0%	▲	94.3%	2023/24	-	Due to attend quarterly surveillance and tested within 4 weeks of due date
		Annually	Surveillance AAA scan (annually)	2023/24	90%	91.8%	84.4%	84.4%	▲	94.4%	2023/24	-	Due to attend annual surveillance and tested within 6 weeks of due date
EQ5		Quarterly	NHS stop smoking services: Local Delivery Plan (LDP) - Number of 12-week quits	31-Mar-25	87	57	51	79	▼	-	-	-	The LDP Standard for NHS Scotland in 2024/25 is to achieve at least 7,026 self-reported successful twelve-week quits through smoking cessation services in the 40% most deprived areas
EQ6		Quarterly	NHS stop smoking services: 12-week quits as a % of the LDP Quarterly Target	31-Mar-25	100%	66.0%	59.0%	91.1%	▼	64.0%	31-Dec-24	-	
FINANCE													
F1	SG	FYTD	Year to date revenue position	31-Jan-26	Breakeven	-£1.856m	-£2.570m	-£5.00m	▲	-	-	-	

Scorecard Detail	
Target Type	FV - Local target/measure set and agreed by NHS Forth Valley; SG - Target/measure set by Scottish Government
Frequency	Frequency of monitoring in relation to scorecard
Measure	Brief description of the measure
Date	Date measure recorded
Target	Agreed target position
Current Position	As at date
Previous Reporting Period	Previous year, quarter, month, week or day dependent on frequency of monitoring
Previous Year	Same reporting period in previous year
Run Chart	✓ - indicates run chart associated with measure is available
Key to Direction of travel	▲ - Improvement in period or better than target
	▼ - Deterioration in period or below target
	◄► - Position maintained
Scotland Position	Scotland measure
Scotland Frequency	Frequency of Scotland measure
Notes	

Forth Valley NHS Schedule of Business 2025/26							
	27 May	**17 June (Private)**	**29 July**	**30 Sept**	**25 Nov**	**27 Jan**	**24 Feb**
Standing Items							
Minute of previous meeting	☑	☑	☑	☑	☑	☑	☑
Action Log	☑		☑	☑	☑	☑	☑
Chair's Update	☑		☑	☑	☑	☑	☑
Board Executive Team Report	☑		☑	☑	☑	☑	☑
Strategic Risk Register	☑		☑	☑	☑	☑	
Patient/Staff Story	☑		☑	☑	☑	☑	☑
Finance Report	☑		☑	☑	☑	☑	☑
Performance Report	☑		☑	☑	☑	☑	☑
HAIRT	☑		☑	☑	☑	☑	
Quality & Safety Report	☑		☑	☑	☑	☑	
Schedule of Business	☑		☑	☑	☑	☑	☑
Minutes							
Assurance Committee Minutes							
Audit & Risk Committee	☑		☑	☑	☑	☑	☑
Clinical Governance Committee	☑		☑	☑	☑	☑	☑
Staff Governance Committee	☑		☑	☑	☑	☑	☑
Strategic Planning, Performance & Resources Committee	☑		☑	☑	☑	☑	☑
Advisory Committees Minutes							
Area Clinical Forum	☑		☑	☑	☑	☑	☑
Area Partnership Forum	☑		☑	☑	☑	☑	☑
IJB Minutes							
Clackmannanshire & Stirling IJB	☑		☑	☑	☑	☑	☑
Falkirk IJB	☑		☑	☑	☑	☑	☑
Directions (as required)	☑		☑	☑	☑	☑	☑
HSCP Annual Performance Reports					☑		
Strategy							
Access Policy			☑				
Annual Delivery Plan 2025/2026 (including Workforce Plan)			☑				
Anti-Racism Strategy							☑

Communications Priorities – Annual Update							
Communications Update			☑			☑	
Development Plan Against Self-Assessment Progress Report							
Digital and eHealth Plan	☑						
Equality Outcomes and Mainstreaming Annual Report - tbc							
Innovation Plan Annual Update			☑				
Mental Health & Wellbeing Strategic Commissioning Plan			☑				
Model Hours for Pharmacy	☑						
Participation & Engagement Strategy Update							
Population Health & Care Strategy				☑			
Quality Strategy Annual Update			☑				
Risk Management Framework							
Risk Appetite & Tolerance							
Whole System Plan – tbc							
Winter Plan					☑		
Performance & Finance							
Annual Accounts		☑					
Draft Financial Plan 2025/2026							
Person Centred Complaints Feedback Annual Report				☑			
Safe Staffing Annual Report							
Whistleblowing Annual Report	☑						
Whistleblowing Standards and Activity Report	☑			☑		☑	
Governance							
Board Assurance Framework – Annual Review (including Performance Framework)							
Code of Corporate Governance – Annual Review							
Corporate Objectives							☑
Dates of Meetings				☑			
Advisory Committee Annual Reports 2024/25 – tbc							